

104TH CONGRESS
2D SESSION

S. 1926

To provide for the integrity of the Medicare program under title XVIII of the Social Security Act, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 28, 1996

Mr. COCHRAN (for himself and Mr. SPECTER) introduced the following bill;
which was read twice and referred to the Committee on Finance

A BILL

To provide for the integrity of the Medicare program under title XVIII of the Social Security Act, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SEC. 11001. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**
4 **RITY ACT; REFERENCES TO OBRA; TABLE OF**
5 **CONTENTS.**

6 (a) SHORT TITLE.—This Act may be cited as the
7 “Emergency Medicare Protection Act of 1996”.

8 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-
9 cept as otherwise specifically provided, whenever in this
10 Act an amendment is expressed in terms of an amendment

1 to or repeal of a section or other provision, the reference
 2 shall be considered to be made to that section or other
 3 provision of the Social Security Act.

4 (c) REFERENCES TO OBRA.—In this Act, the terms
 5 “OBRA–1986”, “OBRA–1987”, “OBRA–1989”,
 6 “OBRA–1990”, and “OBRA–1993” refer to the Omnibus
 7 Budget Reconciliation Act of 1986 (Public Law 99–509),
 8 the Omnibus Budget Reconciliation Act of 1987 (Public
 9 Law 100–203), the Omnibus Budget Reconciliation Act
 10 of 1989 (Public Law 101–239), the Omnibus Budget Rec-
 11 onciliation Act of 1990 (Public Law 101–508), and the
 12 Omnibus Budget Reconciliation Act of 1993 (Public Law
 13 103–66), respectively.

14 (d) TABLE OF CONTENTS.—The table of contents of
 15 this Act is as follows:

Sec. 11001. Short title; amendments to Social Security Act; references to
 OBRA; table of contents.

TITLE I—MEDICARE SAVINGS

Subtitle A—Provisions Relating to Part A

Sec. 11101. Updates for PPS hospitals.

Sec. 11102. Maintaining savings from temporary reduction in PPS capital
 rates.

Sec. 11103. Reduction in adjustment for indirect medical education.

Sec. 11104. Revisions in determination of amount of payment for medical edu-
 cation.

Sec. 11105. Elimination of IME and DSH payments attributable to outlier
 payments.

Sec. 11106. Treatment of transfer cases.

Sec. 11107. Moratorium on new long-term care hospital exclusions.

Sec. 11108. Payments to hospitals excluded from PPS.

Sec. 11109. Reductions to capital payments for PPS-exempt hospitals.

Sec. 11110. Maintaining savings resulting from temporary freeze on payment
 increases for skilled nursing facilities.

Sec. 11111. Interim prospective payment for skilled nursing facilities.

Sec. 11112. Full prospective payment system for skilled nursing facilities.

- Sec. 11113. Salary equivalency guidelines for therapy services.
- Sec. 11114. Graduate medical education, indirect medical education, and disproportionate share hospital payments for managed care enrollees.
- Sec. 11115. Sole community hospitals.
- Sec. 11116. Rural primary care hospital program.
- Sec. 11117. Rural referral centers.
- Sec. 11118. Telemedicine.
- Sec. 11119. Establishment of rural health outreach grant program.
- Sec. 11120. Medicare-dependent, small, rural hospital payment extension.

Subtitle B—Provisions Relating to Part B

- Sec. 11121. Payments for physicians' services.
- Sec. 11122. Practice expense relative value units.
- Sec. 11123. Single fee for surgery.
- Sec. 11124. Incentives to control high volume for in-hospital physicians' services.
- Sec. 11125. Ambulatory surgical center service updates.
- Sec. 11126. Oxygen and oxygen equipment, other durable medical equipment and orthotics and prosthetics.
- Sec. 11127. Elimination of formula-driven overpayments for certain outpatient hospital services.
- Sec. 11128. Extension of reductions in payments for costs of hospital outpatient services.
- Sec. 11129. Prospective payment for hospital outpatient department services.
- Sec. 11130. Waive cost-sharing for mammography.
- Sec. 11131. Annual mammograms.
- Sec. 11132. Coverage of colorectal screening.
- Sec. 11133. Payments for vaccines and vaccine administration.
- Sec. 11134. Diabetes screening benefits.
- Sec. 11135. Respite benefit.
- Sec. 11136. Payments to physician assistants, nurse practitioners, and clinical nurse specialists.

Subtitle C—Provisions Relating to Parts A and B

- Sec. 11141. Centers of excellence.
- Sec. 11142. Maintaining savings resulting from temporary freeze on payment increases for home health services.
- Sec. 11143. Interim payments for home health services.
- Sec. 11144. Prospective payment for home health services.
- Sec. 11145. Payment based on location where home health service is furnished.
- Sec. 11146. Elimination of periodic interim payments for home health agencies.
- Sec. 11147. Permanent extension of certain secondary payer provisions.

Subtitle D—Medicare Part B Premium

- Sec. 11161. Part B premium.

TITLE II—EXPANDED MEDICARE CHOICE

- Sec. 11201. Expanded choice under Medicare.
- Sec. 11202. Broader choice among managed care organizations.
- Sec. 11203. Development of Federal standards.

- Sec. 11204. Applicability of Medicare rates to enrollees who use an out-of-plan provider of services.
- Sec. 11205. Substitution of quality measurement system for private enrollment requirement.
- Sec. 11206. HMO competitive pricing and related demonstrations.
- Sec. 11207. Elimination of health care prepayment plan option for entities eligible to participate under part C.
- Sec. 11208. Medigap reforms.
- Sec. 11209. Standardized benefits packages.
- Sec. 11210. Antitrust rule of reason standard.
- Sec. 11211. Reform of the clinical laboratory improvement amendments of 1988.
- Sec. 11212. Modifications to exceptions for certain arrangements.

TITLE III—NATIONAL COMMISSION ON MEDICARE REFORM

- Sec. 11301. Establishment of Commission.
- Sec. 11302. Duties of the Commission.
- Sec. 11303. Powers of the Commission.
- Sec. 11304. Commission personnel matters.
- Sec. 11305. Termination of the Commission.
- Sec. 11306. Congressional consideration of Commission proposals.
- Sec. 11307. Authorization of appropriations.

1 **TITLE I—MEDICARE SAVINGS**

2 **Subtitle A—Provisions Relating to**

3 **Part A**

4 **SEC. 11101. UPDATES FOR PPS HOSPITALS.**

- 5 (a) UPDATE FACTORS.—Section 1886(b)(3)(B)(i)
- 6 (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended by striking
- 7 subclauses (XII) and (XIII) and inserting the following:
- 8 “(XII) for each of the fiscal years 1997 through
- 9 2002, the market basket percentage increase minus
- 10 1.5 percentage points for hospitals in all areas, and
- 11 “(XIII) for fiscal year 2003 and each subse-
- 12 quent fiscal year, the market basket percentage in-
- 13 crease for hospitals in all areas.”.
- 14 (b) ADJUSTMENTS FOR CASE MIX WHEN RECALI-
- 15 BRATING DRGS.—

(1) IN GENERAL.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended by adding at the end the following:

“(F) ADJUSTING FOR ESTIMATED CHANGE IN CASE MIX.—

“(i) IN GENERAL.—Effective for discharges occurring in a fiscal year in which the Secretary implements significant changes (as defined by the Secretary) in the diagnosis-related group classification system and thereafter, the Secretary may (subject to clause (ii)) adjust the standardized amounts to take into account estimated case mix increase not attributable to real case mix increase anticipated to occur during the fiscal year to which the standardized amounts apply.

“(ii) REFINEMENT.—With regard to the adjustment described in clause (i), if the Secretary determines, based on data taken from the fiscal year to which the adjustment applied, that the amount of the adjustment varied from the actual amount of case mix increase not attributable to real case mix increase by more than 0.25 percentage points, the Secretary shall

1 make a prospective adjustment to the standard-
2 ized amounts to correct for the variance.”.

3 (2) PROPAC RECOMMENDATIONS.—Section
4 1886(e)(2)(A) (42 U.S.C. 1395ww(e)(2)(A)) is
5 amended by adding at the end the following: “With
6 respect to subsection (d) hospitals, the Commission’s
7 recommendation regarding the appropriate percent-
8 age change shall take into account the anticipated
9 difference during the fiscal year between the change
10 in the average weighting factor and the change in
11 real case mix.”.

12 **SEC. 11102. MAINTAINING SAVINGS FROM TEMPORARY RE-**
13 **DUCTION IN PPS CAPITAL RATES.**

14 Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A))
15 is amended by adding at the end the following: “In addi-
16 tion to the reduction described in the preceding sentence,
17 for discharges occurring after October 1, 1996, the Sec-
18 retary shall reduce by 15.7 percent the unadjusted stand-
19 ard Federal capital payment rate (as described in section
20 412.308(c) of volume 42 of the Code of Federal Regula-
21 tions, as in effect on September 30, 1996) and shall re-
22 duce by 15.7 percent the unadjusted hospital-specific rate
23 (as described in section 412.328(e)(1) of volume 42 of the
24 Code of Federal Regulations, as in effect on September
25 30, 1996).”.

1 **SEC. 11103. REDUCTION IN ADJUSTMENT FOR INDIRECT**
 2 **MEDICAL EDUCATION.**

3 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42
 4 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as fol-
 5 lows:

6 “(ii) For purposes of clause (i)(II), the indirect
 7 teaching adjustment factor for discharges occur-
 8 ring—

9 “(I) on or after October 1, 1988 and be-
 10 fore October 1, 1996, is equal to $1.89 \times$
 11 $((1+r)^n - 1)$,

12 “(II) during fiscal year 1997, is equal to
 13 $1.60 \times ((1+r)^n - 1)$,

14 “(III) during fiscal year 1998, is equal to
 15 $1.55 \times ((1+r)^n - 1)$, and

16 “(IV) during or after fiscal year 1999, is
 17 equal to $1.47 \times ((1+r)^n - 1)$,

18 where ‘r’ is the ratio of the hospital’s full-time equiv-
 19 alent interns and residents to beds and ‘n’ equals
 20 .405.”.

21 (b) CONFORMING AMENDMENT RELATING TO DE-
 22 TERMINATION OF STANDARDIZED AMOUNTS.—Section
 23 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is
 24 amended by adding at the end the following: “except that
 25 the Secretary shall not take into account any reductions
 26 in the amount of additional payments under subsection

1 (d)(5)(B)(ii) resulting from the amendments made by sec-
 2 tion 11103(a) of the Emergency Medicare Protection Act
 3 of 1996.”.

4 (c) ALTERNATIVE TO RESTANDARDIZATION OF
 5 COSTS.—Section 1886(d)(3)(A) (42 U.S.C.
 6 1395ww(d)(3)(A)) is amended by adding at the end the
 7 following:

8 “(vi) ALTERNATIVE TO RESTANDARDIZATION
 9 OF COSTS.—Notwithstanding clauses (i) through (v),
 10 if changes in the amount of payment under sub-
 11 sections (d)(3)(E), (d)(5)(B), or (d)(5)(F) would
 12 otherwise require the Secretary to restandardize hos-
 13 pital costs under subsection (d)(2)(C), the Secretary
 14 may compute payment amounts under this subpara-
 15 graph in a manner that assures that aggregate pay-
 16 ments under this subsection in a fiscal year are not
 17 greater or less than those that would have been
 18 made in the year if the Secretary had restandardized
 19 hospital costs under subsection (d)(2)(C).”.

20 **SEC. 11104. REVISIONS IN DETERMINATION OF AMOUNT OF**
 21 **PAYMENT FOR MEDICAL EDUCATION.**

22 (a) INDIRECT MEDICAL EDUCATION.—

23 (1) IN GENERAL.—Section 1886(d)(5)(B) (42
 24 U.S.C. 1395ww(d)(5)(B)), as amended by section
 25 11103(a), is amended—

1 (A) in clause (ii), by inserting “, subject to
2 clause (vi)” after “clause (i)(II)”, and

3 (B) by adding at the end the following:

4 “(v) In determining such adjustment with re-
5 spect to a hospital for discharges occurring on or
6 after October 1, 1996—

7 “(I) the total number of interns and resi-
8 dents in either a hospital or nonhospital setting
9 may not exceed the number of interns and resi-
10 dents in the hospital with respect to the hos-
11 pital’s cost reporting period ending on or before
12 December 31, 1995, and

13 “(II) the number of interns and residents
14 who are not primary care residents as defined
15 in subsection (h)(5)(H) or residents in obstet-
16 rics and gynecology, may not exceed the num-
17 ber of such residents as of such cost reporting
18 period.

19 “(vi) For purposes of clause (ii), ‘r’ may not ex-
20 ceed the ratio of the number of interns and residents
21 as determined under clause (v) with respect to the
22 hospital for its most recent cost reporting period
23 ending on or before December 31, 1995, to the hos-
24 pital’s available beds (as defined by the Secretary)
25 during such cost reporting period.”.

1 (2) PAYMENT FOR INTERNS AND RESIDENTS
 2 PROVIDING OFF-SITE SERVICES.—Section
 3 1886(d)(5)(B)(iv) (U.S.C. 42 1395ww(d)(5)(B)(iv))
 4 is amended to read as follows:

5 “(iv) Effective for discharges occurring on or
 6 after October 1, 1996, all the time spent by an in-
 7 tern or resident in patient care activities under an
 8 approved medical residency training program at an
 9 entity in a nonhospital setting shall be counted to-
 10 ward the determination of full-time equivalency if
 11 the hospital incurs all, or substantially all, of the
 12 costs for the training program in that setting.”.

13 (b) DIRECT GRADUATE MEDICAL EDUCATION.—

14 (1) LIMITATION ON NUMBER OF RESIDENTS.—
 15 section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is
 16 amended by adding at the end the following:

17 “(F) LIMITATION ON NUMBER OF RESI-
 18 DENTS FOR CERTAIN FISCAL YEARS.—Such
 19 rules shall provide that for purposes of a cost
 20 reporting period beginning on or after October
 21 1, 1996—

22 “(i) the total number of full-time
 23 equivalent residents (as determined under
 24 this paragraph) with respect to a hospital’s
 25 approved medical residency training pro-

1 gram may not exceed the number of full-
 2 time equivalent residents with respect to
 3 the hospital's cost reporting period ending
 4 on or before December 31, 1995, and

5 “(ii) the number of a hospital's full-
 6 time-equivalent residents as determined
 7 under this paragraph who are not primary
 8 care residents (as defined in paragraph
 9 (5)(H)) or residents in obstetrics and gyn-
 10 ecology may not exceed the number of such
 11 residents as of such cost reporting period.

12 “(G) ADJUSTMENTS TO LIMITATIONS.—

13 The Secretary may adjust the limitations speci-
 14 fied in subparagraph (F) if a hospital has a sig-
 15 nificant increase in the number of primary care
 16 or obstetrics and gynecology interns or resi-
 17 dents after June 30, 1995.”.

18 (2) PERMITTING PAYMENT TO NONHOSPITAL
 19 PROVIDERS.—Section 1886 (42 U.S.C. 1395(ww)) is
 20 amended by adding at the end the following:

21 “(j) PAYMENT TO NONHOSPITAL PROVIDERS.—

22 “(1) IN GENERAL.—Beginning with cost report-
 23 ing periods beginning on or after October 1, 1996,
 24 the Secretary may establish rules to make payments
 25 (in such amounts and in such form, and from each

1 of the trust funds under this title, as the Secretary
 2 considers appropriate) to federally qualified health
 3 centers (as defined in section 1861(aa)(4)) and rural
 4 health clinics (as defined in section 1861(aa)(2)) for
 5 the direct costs of medical education, if such costs
 6 are incurred in the operation of an approved medical
 7 residency training program described in subsection
 8 (h). The Secretary may designate additional entities
 9 as eligible organizations for such payments as the
 10 Secretary determines to be appropriate.

11 “(2) COORDINATION WITH PAYMENTS UNDER
 12 PART C.—No payments shall be made under para-
 13 graph (1) for costs with respect to which payment
 14 is made under section 1851F(m).”.

15 (3) PROHIBITION ON DOUBLE PAYMENTS.—
 16 Section 1886(h)(3)(B) (42 U.S.C.
 17 1395ww(h)(3)(B)) is amended by adding at the end
 18 the following new flush sentence: “The Secretary
 19 shall reduce the aggregate approved amount to the
 20 extent payment is made under subsection (j) for
 21 residents included in the hospital’s full-time equiva-
 22 lent residents.”.

23 (c) COMMISSION ON MEDICAL EDUCATION AND
 24 WORKFORCE PRIORITIES.—

1 (1) IN GENERAL.—There is established within
2 the Department of Health and Human Services a
3 Commission to be known as the National Commis-
4 sion on Medical Education and Workforce Priorities
5 (in this subsection referred to as the “Commis-
6 sion”).

7 (2) DUTIES.—The Commission shall have the
8 following responsibilities:

9 (A) To develop and recommend to the Sec-
10 retary (in this subsection referred to as the
11 “Secretary”) specific policies to address the
12 preservation of the research and educational ca-
13 pacity of the Nation’s academic health centers
14 and the supply, composition, and support of the
15 future health care workforce including—

16 (i) the financing of graduate medical
17 education,

18 (ii) issues relating to children’s and
19 specialty hospitals,

20 (iii) policies regarding international
21 medical school graduates, and

22 (iv) the relationship of graduate medi-
23 cal education and service generated in-
24 come.

1 (B) To make recommendations concerning
2 the most effective allocation of training re-
3 sources to ensure that the numbers and com-
4 petencies of health care professionals are re-
5 sponsive to the Nation's needs.

6 (3) COMPOSITION.—

7 (A) QUALIFICATIONS.—The Commission
8 shall consist of 15 members appointed by the
9 Secretary, and shall to the extent feasible in-
10 clude—

11 (i) individuals nationally recognized
12 for expertise in health economics, medical
13 education financing, medical practice, issues
14 relating to the composition of the health
15 care workforce, research on and develop-
16 ment of technological and scientific ad-
17 vances in health care, and other related
18 fields; and

19 (ii) health care professionals including
20 physicians (both faculty and nonfaculty),
21 consumers, a dean and a chief executive of-
22 ficer of an academic health center or a
23 teaching hospital, and representatives from
24 health insurance, managed care, and medi-
25 cal workforce accrediting organizations.

1 (B) NATIONAL REPRESENTATION.—To the
2 extent feasible, the membership of the Commis-
3 sion—

4 (i) shall represent the various geo-
5 graphic regions of the United States,

6 (ii) shall reflect the racial, ethnic, and
7 gender composition of the United States;
8 and

9 (iii) shall be broadly representative of
10 medical schools, academic health centers,
11 teaching hospitals, and schools involved in
12 the training of nonphysician providers of
13 health services.

14 (4) TERMS OF OFFICE.—Members of the Com-
15 mission shall first be appointed no later than Janu-
16 ary 1, 1997, for a term of two and one-half years.

17 (5) EX OFFICIO MEMBERS.—In addition to the
18 members appointed pursuant to paragraph (3), the
19 Commission shall include—

20 (A) the Secretary of Veterans Affairs, and
21 the Secretary of Defense (or a designee of each
22 such official); and

23 (B) such additional individuals as may be
24 designated by the Secretary from among Fed-
25 eral officers or employees.

1 (6) CHAIR.—The Secretary shall designate an
2 individual from among the members appointed pur-
3 suant to paragraph (3) to serve as the chair of the
4 Commission.

5 (7) QUORUM.—Nine members of the Commis-
6 sion shall constitute a quorum, but a lesser number
7 may hold hearings.

8 (8) VACANCIES.—Any vacancy in the Commis-
9 sion shall not affect its power to function.

10 (9) COMPENSATION.—Each member of the
11 Commission who is not otherwise employed by the
12 United States Government shall receive compensa-
13 tion at a rate equal to the daily rate prescribed for
14 GS-18 under the General Schedule under section
15 5332 of title 5, United States Code, for each day,
16 including travel time, such member is engaged in the
17 actual performance of duties as a member of the
18 Commission. A member of the Commission who is
19 an officer or employee of the United States Govern-
20 ment shall serve without additional compensation.
21 All members of the Commission shall be reimbursed
22 for travel, subsistence, and other necessary expenses
23 incurred by them in the performance of their duties.

1 (10) CERTAIN AUTHORITIES AND DUTIES.—In
2 order to carry out the provisions of this subsection,
3 the Commission is authorized to—

4 (A) collect such information, hold such
5 hearings, and sit and act at such times and
6 places, either as a whole or by subcommittee,
7 and request the attendance and testimony of
8 such witnesses and the production of such docu-
9 ments as the Commission may consider advis-
10 able; and

11 (B) request the cooperation and assistance
12 of Federal departments, agencies, and instru-
13 mentalities, and such departments, agencies,
14 and instrumentalities are authorized to provide
15 such cooperation and assistance.

16 (11) REPORTS.—The Commission shall submit
17 to the Secretary a preliminary report not later than
18 January 1, 1998, and a final report not later than
19 January 1, 1999, making recommendations on the
20 matters specified in paragraph (2).

21 (12) TERMINATION.—The Commission shall
22 terminate on July 1, 2000.

23 (13) AUTHORIZATION OF APPROPRIATIONS.—
24 There is authorized to be appropriated to the Sec-
25 retary for use in carrying out this subsection such

1 sums as may be necessary for each of fiscal years
 2 1997, 1998, 1999, and 2000. Funds appropriated
 3 for fiscal year 2000 shall remain available until ex-
 4 pended, or until the Commission is terminated,
 5 whichever occurs first.

6 **SEC. 11105. ELIMINATION OF IME AND DSH PAYMENTS AT-**
 7 **TRIBUTABLE TO OUTLIER PAYMENTS.**

8 (a) **INDIRECT MEDICAL EDUCATION.**—Section
 9 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is
 10 amended by inserting “, for cases qualifying for additional
 11 payment under subparagraph (A)(i),” before “the amount
 12 paid to the hospital under subparagraph (A)”.

13 (b) **DISPROPORTIONATE SHARE ADJUSTMENTS.**—
 14 Section 1886(d)(5)(F)(ii)(I) (42 U.S.C.
 15 1395ww(d)(5)(F)(ii)(I)) is amended by inserting “, for
 16 cases qualifying for additional payment under subpara-
 17 graph (A)(i),” before “the amount paid to the hospital
 18 under subparagraph (A)”.

19 (c) **COST OUTLIER PAYMENTS.**—Section
 20 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is
 21 amended by striking “exceed the applicable DRG prospec-
 22 tive payment rate” and inserting “exceed the sum of the
 23 applicable DRG prospective payment rate plus any
 24 amounts payable under paragraphs (d)(5)(B) and
 25 (d)(5)(F)”.

1 (d) EFFECTIVE DATE.—The amendments in this sec-
 2 tion apply to discharges occurring on or after October 1,
 3 1996.

4 **SEC. 11106. TREATMENT OF TRANSFER CASES.**

5 Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I))
 6 of the Act is amended by adding at the end the following:

7 “(iii) CERTAIN TRANSFERS.—Effective for discharges
 8 occurring on or after October 1, 1996, transfer cases (as
 9 otherwise defined by the Secretary) shall also include cases
 10 in which a patient is transferred from a subsection (d)
 11 hospital to a hospital or hospital unit that is not a sub-
 12 section (d) hospital (under section 1886(d)(1)(B) and im-
 13 plementing regulations) or to a skilled nursing facility for
 14 the purpose of receiving extended care services.”.

15 **SEC. 11107. MORATORIUM ON NEW LONG-TERM CARE HOS-**
 16 **PITAL EXCLUSIONS.**

17 Section 1886(d)(1)(B)(iv) (42 U.S.C.
 18 1395ww(d)(1)(B)(iv)) is amended by inserting “(and had
 19 such an average on the date of enactment of the Emer-
 20 gency Medicare Protection Act of 1996)” before the
 21 comma.

1 **SEC. 11108. PAYMENTS TO HOSPITALS EXCLUDED FROM**
 2 **PPS.**

3 (a) REDUCTIONS IN UPDATES.—Section
 4 1886(b)(3)(B)(ii) (42 U.S.C. 1395ww(b)(3)(B)(ii)) is
 5 amended—

6 (1) in subclause (V)—

7 (A) by striking “through 1997” and insert-
 8 ing “through October 1, 1996”, and

9 (B) by striking “and”,

10 (2) by renumbering subclause (VI) as subclause
 11 (VII), and

12 (3) by inserting after subclause (V) the follow-
 13 ing subclause:

14 “(VI) fiscal years 1997 through 2002, the
 15 market basket percentage increase minus 1.5
 16 percentage points, and”.

17 (b) REBASING FOR PPS-EXEMPT HOSPITALS.—Sec-
 18 tion 1886(b)(3)(A)) (42 U.S.C. 1395ww(b)(3)(A)) is
 19 amended to read as follows:

20 “(3)(A)(i) Subject to clauses (ii) and (iii), and except
 21 as provided in subparagraphs (C), (D), and (E), for pur-
 22 poses of this subsection, the term ‘target amount’
 23 means—

24 “(I) with respect to the first 12-month cost re-
 25 porting period in which this subparagraph is applied
 26 to the hospital, the average allowable operating costs

1 of inpatient hospital services (as defined in sub-
 2 section (a)(4)) recognized under this title for such
 3 hospital for the hospital's two most recent 12-month
 4 cost reporting periods beginning on or after October
 5 1, 1991, subject to the floor and ceiling for target
 6 amounts as specified in clause (ii), and increased by
 7 the applicable percentage increases under subpara-
 8 graph (B)(ii) for the hospital's succeeding cost re-
 9 porting periods beginning before fiscal year 1997, or
 10 “(II) with respect to a later cost reporting pe-
 11 riod, the target amount for the preceding cost re-
 12 porting period, increased by the applicable percent-
 13 age increase under subparagraph (B)(ii).
 14 “(ii) Subject to clause (iii), the target amount deter-
 15 mined under this subparagraph for a hospital or unit shall
 16 not be less than 70 percent nor more than 150 percent
 17 of the national mean (adjusted by an appropriate wage
 18 index) of the operating costs of inpatient hospital services
 19 determined under this paragraph for hospitals (and units
 20 thereof as applicable) of each type of hospital described
 21 in subsection (d)(1)(B) for the cost reporting periods
 22 noted in clause (i)(I) and updated by the applicable per-
 23 centage increase under subparagraph (B)(ii).
 24 “(iii) In the case of a hospital that does not have a
 25 cost reporting period beginning before October 1, 1991—

1 “(I) with respect to cost reporting periods be-
 2 ginning during the hospital’s first two fiscal years of
 3 operation, the amount of payment made under this
 4 title with respect to operating costs of inpatient hos-
 5 pital services (as defined in subsection (a)(4)) shall
 6 be the reasonable costs for providing such services,
 7 except that such amount may not exceed 150 per-
 8 cent of the national mean as determined and up-
 9 dated in clause (ii), and

10 “(II) with respect to a later cost reporting pe-
 11 riod, clauses (i) and (ii) shall apply to such hospital
 12 except that the target amount for the hospital shall
 13 be the average allowable operating costs of inpatient
 14 hospital services (as defined in subsection (a)(4))
 15 recognized under this title for the hospital’s first two
 16 12-month cost reporting periods beginning at least
 17 one year after the hospital accepts its first patient.”.

18 (c) EXCEPTIONS AND ADJUSTMENTS.—Section
 19 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is
 20 amended by inserting the following after the first sen-
 21 tence: “The exemption from, or an exception and adjust-
 22 ment to, the method under this subsection for determining
 23 the amount of payment to a hospital is limited to situa-
 24 tions where a hospital’s allowable operating costs of inpa-
 25 tient services recognized under this title for the 12-month

1 cost reporting period exceeds 150 percent of the hospital's
 2 target amount (adjusted by the appropriate wage index)
 3 for such cost reporting period.”.

4 (d) ELIMINATION OF INCENTIVE PAYMENTS.—Sec-
 5 tion 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended to
 6 read as follows:

7 “(b)(1) Notwithstanding section 1814(b), but subject
 8 to the provisions of section 1813 and paragraph (2) of
 9 this subsection, if the operating costs of inpatient hospital
 10 services (as defined in subsection (a)(4)) of a hospital
 11 (other than a subsection (d) hospital, as described in sub-
 12 section (d)(1)(B)) for a cost reporting period subject to
 13 this paragraph—

14 “(A) are less than or equal to 110 percent of
 15 the target amount (as defined in paragraph (3)) for
 16 that hospital for that period, the amount of the pay-
 17 ment with respect to such operating costs payable
 18 under part A on a per discharge basis shall be equal
 19 to such operating costs or the target amount, which-
 20 ever is less; or

21 “(B) are greater than the target amount by at
 22 least 10 percent, the amount of the payment with
 23 respect to such operating costs payable under part
 24 A on a per discharge or per admission basis (as ap-
 25 plicable) shall be equal to the sum of—

1 “(i) the target amount, plus

2 “(ii) an additional amount equal to 50 per-
3 cent of the amount by which the operating costs
4 exceed 110 percent of the target amount after
5 any exceptions or adjustments are made to such
6 target amount for the cost reporting period (ex-
7 cept that such additional amount may not ex-
8 ceed 20 percent of the target amount).”.

9 (e) EFFECTIVE DATE.—Except as otherwise speci-
10 fied, the amendments made by this section apply to cost
11 reporting periods beginning on or after October 1, 1996.

12 (f) DISCHARGES.—Effective with discharges occur-
13 ring on or after April 1, 1997, a rehabilitation hospital
14 (or distinct part rehabilitation unit) or long-term hospital
15 that is excluded from the prospective payment system
16 under section 1886(d)(1)(B) shall submit patient assess-
17 ment data based on a uniform minimum data set defined
18 by the Secretary that can be used to develop a patient’s
19 plan of care and could be used to classify patients under
20 a prospective payment system. To the extent the Secretary
21 determines appropriate, the Secretary may require other
22 excluded hospitals to submit patient assessment data.

1 **SEC. 11109. REDUCTIONS TO CAPITAL PAYMENTS FOR PPS-**
 2 **EXEMPT HOSPITALS.**

3 Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is
 4 amended by adding at the end the following new subpara-
 5 graph:

6 “(T) REDUCTIONS FOR PPS-EXEMPT HOSPITALS.—
 7 Such regulations shall provide that, in determining the
 8 amount of the payments that may be made under this title
 9 with respect to the capital-related costs of inpatient hos-
 10 pital services furnished by a hospital that is not a sub-
 11 section (d) hospital (as defined in section 1886(d)(1)(B))
 12 or a subsection (d) Puerto Rico hospital (as defined in
 13 section 1886(d)(9)(A)), the Secretary shall reduce the
 14 amounts of such payments otherwise established under
 15 this title by 15 percent for payment attributable to por-
 16 tions of cost reporting periods occurring on or after Octo-
 17 ber 1, 1996, through fiscal year 2002.”.

18 **SEC. 11110. MAINTAINING SAVINGS RESULTING FROM TEM-**
 19 **PORARY FREEZE ON PAYMENT INCREASES**
 20 **FOR SKILLED NURSING FACILITIES.**

21 (a) BASING UPDATES TO PER DIEM COST LIMITS
 22 EFFECTIVE FOR FISCAL YEAR 1996 ON LIMITS FOR FIS-
 23 CAL YEAR 1993.—

24 (1) IN GENERAL.—The last sentence of section
 25 1888(a) (42 U.S.C. 1395yy(a)) is amended by add-
 26 ing at the end the following: “, except that the limits

1 effective October 1, 1996, shall be based on the lim-
 2 its effective on October 1, 1992, and shall not take
 3 into account any changes in the routine service costs
 4 of skilled nursing facilities occurring during cost re-
 5 porting periods which began during fiscal year 1994
 6 or fiscal year 1995.”.

7 (2) NO EXCEPTIONS PERMITTED BASED ON
 8 AMENDMENT.—The Secretary of Health and Human
 9 Services shall not consider the amendment made by
 10 paragraph (1) in making any adjustments pursuant
 11 to section 1888(c) of the Social Security Act.

12 (b) PAYMENTS DETERMINED ON PROSPECTIVE
 13 BASIS.—Prospective payments made to skilled nursing fa-
 14 cilities under section 1888(d) of the Social Security Act
 15 for cost reporting periods beginning on or after October
 16 1, 1996, shall be based on the rates effective for cost re-
 17 porting periods beginning October 1, 1992, and before Oc-
 18 tober 1, 1993, and shall not take into account any changes
 19 in the costs of services occurring during cost reporting pe-
 20 riods which began during fiscal year 1994 or fiscal year
 21 1995.

22 **SEC. 11111. INTERIM PROSPECTIVE PAYMENT FOR SKILLED**
 23 **NURSING FACILITIES.**

24 (a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy)
 25 is amended by adding at the end the following:

1 “(e) The Secretary shall, for cost reporting periods
2 beginning on or after October 1, 1996, provide for pay-
3 ment for routine service costs (excluding capital-related
4 costs) of extended care services in accordance with a pro-
5 spective payment system established by the Secretary in
6 the amounts provided in subsection (f), subject to the ex-
7 ceptions and limitations in subsections (g) and (h).

8 “(f)(1) The amount of payment under subsection (e)
9 shall be determined on a per diem basis.

10 “(2) The Secretary shall compute the routine service
11 costs per diem in a base year (determined by the Sec-
12 retary) for each skilled nursing facility, and shall update
13 the per diem rate on the basis of a market basket and
14 other factors as the Secretary determines appropriate. In
15 determining the per diem rate, the Secretary shall exclude
16 increases in routine service costs associated with fiscal
17 year 1994 and fiscal year 1995.

18 “(3) The base year routine service costs used to de-
19 termine the per diem rate applicable to a skilled nursing
20 facility may not exceed the following limits:

21 “(A) With respect to skilled nursing facilities
22 located in rural areas, the limit shall be equal to 112
23 percent of the mean per diem routine service costs
24 in a base year (determined by the Secretary) for

1 freestanding skilled nursing facilities located in rural
2 areas within the same region.

3 “(B) With respect to skilled nursing facilities
4 located in urban areas, the limit shall be equal to
5 112 percent of the mean per diem routine service
6 costs in a base year (determined by the Secretary)
7 for freestanding skilled nursing facilities located in
8 urban areas within the same region.

9 “(C) For purposes of this subsection, urban
10 and rural areas shall be determined in the same
11 manner as for purposes of subsection (a), and the
12 term ‘region’ shall have the same meaning as under
13 section 1886(d)(2)(D).

14 “(D) In establishing limits under this sub-
15 section, the Secretary may make appropriate adjust-
16 ments to the labor-related portion of the costs based
17 upon on a wage index and other factors as the Sec-
18 retary determines appropriate.

19 “(E) In establishing the routine cost limits
20 under this subsection, the Secretary shall exclude in-
21 creases in routine service costs associated with fiscal
22 year 1994 and fiscal year 1995.

23 “(4) Skilled nursing facilities entering the Medicare
24 program subsequent to the base period, determined in sub-
25 section (f)(1), shall receive a routine payment rate equal

1 to the mean per diem routine costs of freestanding skilled
2 nursing facilities in the urban or rural area in which they
3 are located by region. The Secretary shall compute these
4 payment rates using per diem costs in a base year (deter-
5 mined by the Secretary) and shall update the rates on the
6 basis of a market basket and other factors as the Sec-
7 retary determines appropriate. In determining the pay-
8 ment rates under this paragraph, the Secretary shall ex-
9 clude increases in routine service costs associated with fis-
10 cal year 1994 and fiscal year 1995.

11 “(5) Effective for cost reporting periods beginning on
12 or after October 1, 1996, low Medicare volume skilled
13 nursing facilities, as described in subsection (d), shall re-
14 ceive payment for routine service costs as otherwise set
15 forth in subsections (e) through (j), except that they may
16 elect to receive payment on the basis of the rates described
17 in subsection (f)(4).

18 “(6) The Secretary may make prospective adjust-
19 ments to the routine payment rates to account for changes
20 in facility patient mix (case mix) as the Secretary deter-
21 mines appropriate. A skilled nursing facility must provide
22 the Secretary with the resident assessment data necessary
23 to develop and implement such a system adjustment. Resi-
24 dent assessment data required under section 1819(b)(3),
25 using the standard instrument designated by the State

1 under section 1819(e)(5), shall be deemed to fulfill this
 2 requirement. Such adjustment shall be made in a manner
 3 which does not increase expenditures for the routine costs
 4 of skilled nursing facility services beyond what would oth-
 5 erwise occur.

6 “(g)(1) Subject to paragraphs (2) and (3), a facility’s
 7 per diem payment rate based on the application of sub-
 8 sections (e) and (f) is the greater of—

9 “(A) its per diem payment amount in the base
 10 year, and

11 “(B) its base year cost per diem up to the re-
 12 gional limit plus any exception amounts that may
 13 have been granted in the base year (adjusted by the
 14 market basket).

15 “(2) The payment rate determined under paragraph
 16 (1) shall not exceed the facility’s cost per diem incurred
 17 in the base year adjusted by the market basket.

18 “(3) Paragraph (1)(A) does not apply if the per diem
 19 payment amount in the base year was determined on the
 20 basis of an exemption under subsection (f)(4).

21 “(h) The Secretary, in making determinations on the
 22 reasonable costs (both capital and operating) of ancillary
 23 services provided by skilled nursing facilities under part
 24 A, shall utilize as an upper limit, the carrier fee schedules
 25 applicable to such services as specified in sections 1834

1 and 1848. This subsection shall not have the effect of miti-
 2 gating other limits on the reasonable costs of ancillary
 3 services currently in effect under part A such as those
 4 specified in section 1861(v)(5)(A).

5 “(i) Exceptions, as described in subsection (c), and
 6 exemptions, as described in the applicable regulations, are
 7 eliminated for cost reporting periods beginning on or after
 8 October 1, 1996.”.

9 (b) CONSOLIDATED BILLING AND UNIFORM COD-
 10 ING.—

11 (1) IN GENERAL.—Section 1862(a) (42 U.S.C.
 12 1395y(a)) is amended—

13 (A) by striking “or” at the end of para-
 14 graph (14),

15 (B) by striking the period at the end of
 16 paragraph (15) and adding a semicolon, and

17 (C) by inserting after paragraph (15) the
 18 following:

19 “(16) which are other than physicians’ services,
 20 services described by sections 1861(s)(2)(K)(i)
 21 through (iii), certified nurse-midwife services, quali-
 22 fied psychologist services, hospice services, and serv-
 23 ices of a certified registered nurse anesthetist, and
 24 which are furnished to an individual who is a resi-
 25 dent of a skilled nursing facility by an entity other

1 than the skilled nursing facility, unless the services
 2 are furnished under arrangements (as defined in sec-
 3 tion 1861(w)(1)) with the entity made by the skilled
 4 nursing facility; or

5 “(17) which are on a claim submitted by a
 6 skilled nursing facility under this title, unless the
 7 claim uses the HCFA common procedure coding sys-
 8 tem.”.

9 (2) CONFORMING AMENDMENT.—Section
 10 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is
 11 amended—

12 (A) by striking “(i)” and inserting “(I)”
 13 and striking “(ii)” and inserting “(II)”,

14 (B) by striking “(H)” and inserting
 15 “(H)(i)”, and

16 (C) by adding at the end the following:

17 “(ii) in the case of skilled nursing facilities
 18 which provide services for which payment may be
 19 made under this title, to have all items and services
 20 (other than physicians’ services, and other than serv-
 21 ices described by section 1861(s)(2)(K) (i) through
 22 (iii), certified nurse-midwife services, qualified psy-
 23 chologist services, hospice services, and services of a
 24 certified registered nurse anesthetist)—

1 “(I) that are furnished to an individual
2 who is a resident of the skilled nursing facility,
3 and

4 “(II) for which the individual is entitled to
5 have payment made under this title, furnished
6 by the skilled nursing facility or otherwise
7 under arrangements (as defined in section
8 1861(w)(1)) made by the skilled nursing facil-
9 ity,”.

10 (3) EFFECTIVE DATE.—The amendments made
11 by this subsection are effective for cost reporting pe-
12 riods beginning on or after October 1, 1996.

13 **SEC. 11112. FULL PROSPECTIVE PAYMENT SYSTEM FOR**
14 **SKILLED NURSING FACILITIES.**

15 (a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy),
16 as added by section 11111(a), is amended by striking sub-
17 sections (e) through (i) and inserting the following:

18 “(e)(1) The Secretary shall provide for payment for
19 all costs of extended care services (including routine serv-
20 ice costs, ancillary costs, and capital related costs) in ac-
21 cordance with a prospective payment system established
22 by the Secretary. Such system shall incorporate an adjust-
23 ment for patient mix (case mix) based on resident assess-
24 ment data and other data as appropriate. A skilled nurs-
25 ing facility must provide the Secretary with the resident

1 assessment data necessary to develop and implement such
 2 a system adjustment. Resident assessment data required
 3 under section 1819(b)(3) using the standard instrument
 4 designated by the State under section 1819(e)(5) fulfills
 5 this requirement.

6 “(2) Prior to implementing the prospective payment
 7 system described in paragraph (1) in a budget neutral
 8 fashion, the Secretary shall reduce, by 7 percent, the per
 9 diem rates for routine costs, and the reasonable costs for
 10 ancillary services and capital for skilled nursing facilities
 11 as such rates and costs are in effect on September 30,
 12 1997.”.

13 (b) EFFECTIVE DATE.—The amendments made by
 14 the preceding subsection apply to cost reporting periods
 15 beginning on or after October 1, 1997.

16 **SEC. 11113. SALARY EQUIVALENCY GUIDELINES FOR THER-**
 17 **APY SERVICES.**

18 Section 1861(v)(5) (42 U.S.C. 1395x(v)(5)) is
 19 amended—

20 (1) by redesignating subparagraph (B) as sub-
 21 paragraph (D),

22 (2) in subparagraph (D), as so redesignated, by
 23 adding “(B), or (C),” after “subparagraph (A),”,

24 (3) by inserting after subparagraph (A) the fol-
 25 lowing:

1 “(B)(i) Effective for services furnished on or after
2 October 1, 1996, the Secretary shall apply guidelines
3 based on the methodology described in clause (ii) relating
4 to occupational therapy services and speech-language pa-
5 thology services, and replace guidelines previously estab-
6 lished under the subparagraph (A) relating to respiratory
7 therapy services and physical therapy services provided
8 under an arrangement with a provider of services or other
9 organization.

10 “(ii) The guidelines for each therapy shall be equal
11 to the sum of—

12 “(I) the sum of an hourly salary rate, plus
13 fringe benefits, plus a rental expense factor (in the
14 same base year), and

15 “(II) an overhead factor (excluding rental ex-
16 penses) equal to 28 percent of the amount deter-
17 mined in subclause (I),

18 adjusted by geographical area using the methodology con-
19 tained in the final regulation of the Secretary published
20 on page 44928 of volume 48 of the Federal Register on
21 September 30, 1983, updated annually from the base year
22 to the current year by an inflation factor.

23 “(iii) The data used in establishing the guidelines
24 under clause (ii) shall be—

1 “(I) in the case of hourly salary rates, for each
2 therapy, the 75th percentile of salaries paid to
3 therapists working full time in an employment rela-
4 tionship in the area, from the most recent available
5 Bureau of Labor Statistics (BLS) hospital salary
6 data for each, increased by 10 percent,

7 “(II) in the case of fringe benefits, for each
8 therapy, an aggregate factor derived from hospital
9 cost reports ending in fiscal year 1991 for BLS sur-
10 vey areas used in subclause (I),

11 “(III) in the case of the rental expense factor,
12 for each therapy, an amount derived from local area
13 rental income data compiled by the Building Owners
14 and Managers Association International for 1991,
15 for BLS survey areas used in subclause (I), and

16 “(IV) in the case of the inflation factor, for
17 each therapy, an amount equal to the average of em-
18 ployment cost indices for wages and benefits of civil-
19 ian hospital, professional technical and clerical work-
20 ers, and private executives, administrators and man-
21 agers, and the Consumer Price Indices (Urban) for
22 Housing and all items less food and energy, weight-
23 ed by the relative proportion that each component
24 represents of the guidelines amounts.

1 “(C) Nothing in subparagraph (B) shall preclude the
 2 Secretary from updating the guidelines using such data
 3 sources and methodology as the Secretary determines to
 4 be appropriate, except that any changes to the data
 5 sources will be made through rulemaking in a manner that
 6 does not increase aggregate spending for such services be-
 7 yond what would otherwise occur.”, and

8 (4) by adding at the end the following:

9 “(E) In applying limitations under section
 10 1861(v)(5), the Secretary shall not recognize an exception
 11 for a provider that entered into a written binding contract
 12 or contingency contract with a therapist, provider or other
 13 organization prior to the date the initial guidelines are
 14 published.”.

15 **SEC. 11114. GRADUATE MEDICAL EDUCATION, INDIRECT**
 16 **MEDICAL EDUCATION, AND DISPROPORTION-**
 17 **ATE SHARE HOSPITAL PAYMENTS FOR MAN-**
 18 **AGED CARE ENROLLEES.**

19 (a) PAYMENTS FOR GRADUATE MEDICAL EDU-
 20 CATION PROGRAMS.—Section 1851F, as added by title II,
 21 is amended by adding at the end the following:

22 “(m) PAYMENTS FOR GRADUATE MEDICAL EDU-
 23 CATION PROGRAMS.—

24 “(1) ADDITIONAL PAYMENT TO BE MADE.—

25 Starting in calendar year 1997, each contract with

1 an eligible organization under this section shall pro-
 2 vide for an additional payment for Medicare's share
 3 of allowable direct graduate medical education costs
 4 incurred by such organization for an approved medi-
 5 cal residency program.

6 “(2) ALLOWABLE COSTS.—If the eligible orga-
 7 nization has an approved medical residency program
 8 that incurs all or substantially all of the costs of the
 9 program, the allowable costs for such program shall
 10 equal the national average per resident amount
 11 times the number of full-time-equivalent residents in
 12 the program in nonhospital settings.

13 “(3) COSTS UNDER CONTRACTS WITH HOS-
 14 PITALS.—If an eligible organization and a hospital
 15 that has an approved medical residency training pro-
 16 gram both voluntarily enter into a written agreement
 17 under which the eligible organization agrees to pay
 18 the hospital for direct graduate medical education
 19 resident time spent in patient care related activities,
 20 then those payments are included within the allow-
 21 able costs payable under paragraph (1).

22 “(4) DEFINITIONS.—As used in this sub-
 23 section—

24 “(A) the terms ‘approved medical residency
 25 program’, ‘direct graduate medical education

1 costs', and 'full-time-equivalent residents' have
 2 the same meanings as under section 1886(h),
 3 "(B) the term 'Medicare's share' means
 4 the amount determined by multiplying the eligi-
 5 ble organization's allowable costs for an ap-
 6 proved medical residency program by the ratio
 7 of the number of individuals enrolled with the
 8 organization under this section to the total
 9 number of individuals enrolled with the organi-
 10 zation, and

11 "(C) the term 'national average per resi-
 12 dent amount' means an amount estimated by
 13 the Secretary to equal the weighted average
 14 amount that would be paid per full-time-equa-
 15 lent resident under section 1886(h) for the cal-
 16 endar year (determined separately for primary
 17 care residency programs as defined under sec-
 18 tion 1886(h) (including obstetrics and gyne-
 19 cology residency programs) and for other resi-
 20 dency programs).".

21 (b) ADDITIONAL PAYMENTS TO HOSPITALS FOR
 22 MANAGED CARE ENROLLEES.—

23 (1) HOSPITAL PAYMENT AMOUNT PER RESI-
 24 DENT.—Section 1886(h)(3) (42 U.S.C.

1 1395ww(h)(3)) is amended by adding at the end the
 2 following:

3 “(D) PAYMENT FOR MANAGED CARE EN-
 4 ROLLEES.—For portions of cost reporting peri-
 5 ods occurring on or after January 1, 1997, the
 6 Secretary shall provide for an additional pay-
 7 ment amount under this subsection for services
 8 furnished to individuals who are enrolled under
 9 a contract with an eligible organization under
 10 part C and who are entitled to part A. Subject
 11 to subsection (d)(11)(E), the amount of such
 12 payment shall be equal to the product of—

13 “(i) the aggregate approved amount
 14 (as defined in subparagraph (B)) for that
 15 period, and

16 “(ii) the fraction of the total number
 17 of inpatient-bed-days (as established by the
 18 Secretary) during the period which are at-
 19 tributable to individuals who are enrolled
 20 in eligible organizations which have con-
 21 tracts under part C and who are entitled
 22 to part A.”.

23 (2) ADDITIONAL PAYMENTS TO HOSPITALS FOR
 24 SUBSECTION (d) HOSPITALS.—Section 1886(d) (42

1 U.S.C. 1395ww(d)) is amended by adding at the end
2 the following:

3 “(11)(A) For portions of cost reporting periods oc-
4 ccurring on or after January 1, 1997, the Secretary shall
5 provide for an additional payment amount for subsection
6 (d) hospitals for services furnished to individuals who are
7 enrolled under a contract with an eligible organization
8 under part C and who are entitled to part A.

9 “(B) Subject to subparagraph (E), the amount of
10 such payment shall be determined by multiplying—

11 “(i) the sum of the amounts determined under
12 subparagraphs (C) and (D), by

13 “(ii) the product of—

14 “(I) the number of discharges attributable
15 to individuals who are enrolled in an organiza-
16 tion having a contract under Part C and who
17 are entitled to Part A, and

18 “(II) the estimated average per discharge
19 amount that would otherwise have been paid
20 under section 1886(d)(1)(A) if the individuals
21 had not been enrolled in an organization having
22 a contract under part C.

23 “(C) The Secretary shall determine an indirect teach-
24 ing adjustment factor equal to the indirect teaching ad-

1 justment factor applicable to the hospital under paragraph
2 (5)(B).

3 “(D) The Secretary shall determine a disproportion-
4 ate share adjustment factor equal to the disproportionate
5 share adjustment percentage applicable to the hospital
6 under paragraph (5)(F).

7 “(E)(i) Payments under this paragraph, subsection
8 (h)(3)(D), and section 1851F(1) for services or discharges
9 occurring in a calendar year shall not exceed the annual
10 limit described in clause (iii).

11 “(ii) At the beginning of each calendar year, if the
12 Secretary determines that the payments described in
13 clause (i) are likely to exceed the limit described in clause
14 (iii), the Secretary shall make an adjustment in the
15 amounts otherwise payable so that total payments will not
16 exceed such limit.

17 “(iii) The payment limit described in this subclause
18 is the sum, over all counties, of the product of the annual
19 per capita payment adjustment amount, described in
20 clause (iv), and the Secretary’s projection of average en-
21 rollment in eligible organizations with contracts under
22 part C.

23 “(iv) The payment adjustment amount described in
24 this clause for a particular county—

1 “(I) for 1997, is 40 percent of the amount in-
 2 cluded in the per capita rate of payment for 1996
 3 determined under section 1876(a)(1)(C) for the pay-
 4 ment adjustments described in section
 5 1851F(e)(4)(C)(ii)(III) increased by the update fac-
 6 tor described in clause (v);

7 “(II) for 1998 is the per capita payment adjust-
 8 ment amount for 1997 as if “40 percent” in sub-
 9 clause (I) was “100 percent”, increased by the up-
 10 date factor described in clause (v); and

11 “(III) for 1999 and subsequent years, is the per
 12 capita payment adjustment amount for the previous
 13 year increased by the update factor described in
 14 clause (v).

15 “(v) The update factor described in clause (iv) is the
 16 Secretary’s projection for the following calendar year of
 17 average per capita growth in the payment adjustments de-
 18 scribed in section 1851F(e)(4)(C)(ii)(III).

19 “(vi) Beginning in 1997, during the month of Janu-
 20 ary, the Secretary shall promulgate the payment limit de-
 21 scribed in clause (iii) for the following calendar year and
 22 the payment adjustment described in clause (ii).”.

23 (c) USE OF INTERIM FINAL REGULATIONS.—The
 24 Secretary of Health and Human Services may issue regu-

lations on an interim final basis to implement this section
and the amendments made by this Act.

SEC. 11115. SOLE COMMUNITY HOSPITALS.

(a) EXPANDING THE CHOICE OF BASE YEARS.—Section 1886(b)(3)(C) (42 U.S.C. 1395ww(b)(3)(C)) is amended—

(1) by striking “or” at the end of clause (iii),

(2) by striking the period at the end of clause

(iv) and inserting “, or”, and

(3) by striking the second sentence and inserting in its place the following:

“(v) If such a substitution results in an increase in the target amount for the hospital, there shall be substituted for the base cost reporting period described in clause (i)—

“(I) a hospital’s cost reporting period (if any) beginning during fiscal year 1987, or

“(II) beginning with discharges occurring in fiscal year 1997, the average of—

“(aa) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital’s cost reporting period (if any) beginning during fiscal year 1992 increased (in a compounded manner) by

the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods beginning in fiscal year 1993 and for discharges occurring in fiscal years 1994, 1995, and 1996, and

“(bb) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital’s cost reporting period (if any) beginning during fiscal year 1993 increased (in a compounded manner) by the applicable percentage increase applied to such hospital under this paragraph for discharges occurring in fiscal years 1994, 1995, and 1996.”.

(b) ELIMINATING THE VOLUME ADJUSTMENT.—Section 1886(d)(5)(D)(ii) (42 U.S.C. 1395ww(d)(5)(D)(ii)) is amended by striking “In” at the beginning and inserting “For cost reporting periods beginning before October 1, 1996, in”.

SEC. 11116. RURAL PRIMARY CARE HOSPITAL PROGRAM.

(a) IN GENERAL.—The heading to section 1820 (42 U.S.C. 1395i–4)) is amended to read as follows:

1 “RURAL PRIMARY CARE HOSPITAL PROGRAM”.

2 (b) EXPANSION OF PROGRAM TO ALL STATES.—Sec-
3 tion 1820(a)(1) (42 U.S.C. 1395i–4(a)(1)) is amended by
4 striking “not more than 7”.

5 (c) MORATORIUM ON NEW ESSENTIAL ACCESS COM-
6 MUNITY HOSPITAL DESIGNATIONS.—Section 1820 (42
7 U.S.C. 1395i–4)) is amended—

8 (1) in subsections (a)(3) and (b)(1)(C), by
9 striking “essential access community hospitals or”
10 after “as”,

11 (2) in subsection (c)(1)(B), by striking “an es-
12 sential access community hospital or” after “is des-
13 ignated as”,

14 (3) in subsection (d)(1), by striking “essential
15 access community hospitals or” after “facilities in
16 the State as”,

17 (4) in subsection (d)(2), by striking “or an es-
18 sential access community hospital” after “rural pri-
19 mary care hospital”,

20 (5) by repealing subsection (e),

21 (6) in subsection (g)(1), by amending subpara-
22 graph (A) to read as follows:

23 “(A) at least one hospital that is not a
24 rural primary care hospital, and”,

25 (7) in subsection (i)—

1 (A) in the heading, by striking “HOS-
 2 PITALS OR” and “BY SECRETARY”,

3 (B) by striking paragraphs (1) and (2)(C),

4 (C) in paragraph (2)(A)(ii), by striking
 5 “subparagraph (B)” and inserting “paragraph
 6 (2)”,

7 (D) by redesignating paragraph (2) as
 8 paragraph (1),

9 (E) by striking the subparagraph designa-
 10 tion “(B)” and inserting “(2) FACILITIES DES-
 11 IGNATED BY THE SECRETARY.—”,

12 (F) by striking the heading to paragraph
 13 (1) (as redesignated by subparagraph (D) of
 14 this paragraph) and the subparagraph designa-
 15 tion “(A)” and inserting “FACILITIES DES-
 16 IGNATED BY THE STATE.—”, and

17 (G) by redesignating clauses (i) through
 18 (iii) of paragraph (1) (as redesignated by sub-
 19 paragraph (D) of this paragraph) as subpara-
 20 graphs (A) through (C), and

21 (8) in paragraphs (1) and (2) of subsection (k),
 22 by striking “an essential access community hospital
 23 or” each time it appears.

24 (d) CONTINUING PARTICIPATION OF RURAL PRI-
 25 MARY CARE HOSPITALS.—Section 1820(i)(1)(A) (42

1 U.S.C. 1395i-4(i)(1)(A)) (as redesignated by subsection
 2 (c)(7) of this section) is amended by inserting before the
 3 semicolon the following: “(or in a State which the Sec-
 4 retary finds would receive a grant under such subsection
 5 during a fiscal year if funds were appropriated for grants
 6 under such subsection for the fiscal year)”.

7 (e) DESIGNATION OF NONPROFIT OR PUBLIC HOS-
 8 PITALS.—Section 1820(f)(1)(A) (42 U.S.C. 1395i-
 9 4(f)(1)(A)) is amended by inserting “is a nonprofit or pub-
 10 lic hospital, and” after “(A)”.

11 (f) ESTABLISHING A MINIMUM SEPARATION DIS-
 12 TANCE BETWEEN FACILITIES.—Section 1820(f)(1) (42
 13 U.S.C. 1395i-4(f)(1)) is amended—

14 (1) by striking “and” at the end of subpara-
 15 graph (G),

16 (2) by striking the period at the end of sub-
 17 paragraph (H) and inserting “; and”, and

18 (3) by adding at the end the following:

19 “(I) is located at least a 35-mile drive from
 20 any rural primary care hospital or hospital, or
 21 is certified by the State as being a necessary
 22 provider of health care services to residents in
 23 the area, because of local geography or service
 24 patterns.”.

1 (g) REMOVAL OF REQUIREMENT FOR PRIOR COMPLI-
 2 ANCE WITH HOSPITAL STANDARDS.—Section
 3 1820(f)(1)(B) (42 U.S.C. 1395i–4(f)(1)(B)) is amended
 4 by striking “and had not been found, on the basis of a
 5 survey under section 1864, to be in violation of any re-
 6 quirement to participate as a hospital under this title”.

7 (h) LIMITATION ON NUMBER OF INPATIENT BEDS.—
 8 The matter in section 1820(f)(1)(F) (42 U.S.C. 1395i–
 9 4(f)(1)(F)) preceding clause (i) is amended by striking
 10 “6” and inserting “15”.

11 (i) LIMITATION ON LENGTH OF INPATIENT STAYS.—
 12 Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended—

13 (1) in the matter in paragraph (1)(F) preceding
 14 clause (i), by striking “subject to paragraph (4),”,

15 (2) in paragraph (1)(F)(i), by striking “72
 16 hours” and inserting “96 hours”, and

17 (3) by striking paragraph (4).

18 (j) CONFORMING CHANGE.—Section 1814(a)(8) (42
 19 U.S.C. 1395f(a)(8)) is amended by striking “within 72
 20 hours” and inserting “within 96 hours”.

21 (k) PERMITTING RURAL PRIMARY CARE HOSPITALS
 22 TO MAINTAIN SWING BEDS.—Section 1820(f)(3) (42
 23 U.S.C. 1395i–4(f)(3)) is amended—

1 (1) in the first sentence, by striking “are used
2 for the furnishing of extended care services” through
3 “paragraph (1)(F))”, and

4 (2) by amending the second sentence to read as
5 follows: “Nothing in this subsection shall be con-
6 strued to prohibit a rural primary care hospital from
7 entering into an agreement under section 1883
8 under which its facilities are used for the furnishing
9 of extended care services.”.

10 (l) CONFORMING CHANGE.—Section 1883 (42 U.S.C.
11 1395tt) is amended by striking “hospital” each place it
12 appears and inserting “hospital or rural primary care hos-
13 pital”.

14 (m) CHANGE IN PAYMENT METHODOLOGY.—Section
15 1814(l)(1) (42 U.S.C. 1395f(l)(1)) is amended by striking
16 “services—” and all that follows through the period and
17 inserting “services is the reasonable cost of the rural pri-
18 mary care hospital in providing such services, as deter-
19 mined under section 1861(v).”.

20 (n) ELIMINATION OF DEADLINE FOR DEVELOPMENT
21 OF PROSPECTIVE PAYMENT SYSTEM.—Section 1814(l)
22 (42 U.S.C. 1395(l)(1)) is amended—

23 (1) by striking paragraph (2), and

24 (2) by striking “(l)(1)” and inserting “(l)”.

1 (o) NO CHANGE IN PAYMENT TO EXISTING ESSEN-
2 TIAL ACCESS COMMUNITY HOSPITALS.—

3 (1) IN GENERAL.—Section
4 1886(d)(5)(D)(iii)(III) (42 U.S.C.
5 1395ww(d)(5)(D)(iii)(III)) is amended—

6 (A) by inserting “was” after “is located in
7 a rural area and”, and

8 (B) by striking “under section 1820(i)(1).”
9 and inserting “under section 1820(i)(1) as in
10 effect on the day before effective date of the
11 Emergency Medicare Protection Act of 1996.
12 The application of a facility that was submitted
13 to the State for designation as an essential ac-
14 cess community hospital prior to January 1,
15 1996, and on which the State had not acted on
16 by that date shall be deemed to have been ap-
17 proved by the Secretary prior to the enactment
18 of the Emergency Medicare Protection Act of
19 1996 if, within 2 months of enactment—

20 “(aa) the State in which the facility is lo-
21 cated determines that such facility meets the
22 criteria for essential access community hospital
23 designation described in section 1820(e) as in
24 effect prior to the enactment of such Act (or

1 solely fails to meet the criteria in section
2 1820(e)(2)), and

3 “(bb) the Secretary determines the facility
4 meets the criteria described in section
5 1820(i)(1)(A) (i) and (iii) as in effect prior to
6 the enactment of such Act.”.

7 (2) CONFORMING AMENDMENT.—Section
8 1886(d)(5)(D)(v) (42 U.S.C. 1395ww(d)(5)(D)(v))
9 is amended—

10 (A) by inserting “was” after “is located in
11 a rural area and”, and

12 (B) by inserting “as in effect on the day
13 before effective date of the Emergency Medicare
14 Protection Act of 1996” after “section
15 1820(I)(1)”.

16 (p) CONFORMING AMENDMENT.—Section 1820(c)(3)
17 (42 U.S.C. 1395i–4(c)(3)) is amended by striking
18 “(i)(2)(C)” and inserting “(i)(2)”.

19 (q) TECHNICAL AMENDMENT.—Section
20 1820(f)(1)(A) (42 U.S.C. 1395i–4(f)(1)(A)) is amended
21 by striking “section 1866(d)(2)(D)” and inserting “sec-
22 tion 1886(d)(2)(D)”.

23 (r) MEDICAL ASSISTANCE FACILITIES.—Limited
24 service rural hospitals participating in a demonstration de-
25 scribed in section 4008(i)(1) of the Omnibus Budget Rec-

1 conciliation Act of 1990 (and any facilities that have ap-
 2 plied for inclusion in the demonstration as of the date of
 3 the enactment of this Act and that would have been in-
 4 cluded by the Secretary under provisions applicable as of
 5 the date of enactment) shall be deemed to be rural pri-
 6 mary care hospitals as long as they continue to meet the
 7 requirements of the demonstration protocol relating to
 8 staffing, services, quality assurance, and related factors.

9 **SEC. 11117. RURAL REFERRAL CENTERS.**

10 (a) PERMANENT GRANDFATHERING OF RURAL RE-
 11 FERRAL CENTER STATUS.—

12 (1) IN GENERAL.—Section 1886(d)(5)(C) (42
 13 U.S.C. 1395ww(d)(5)(C)) is amended by adding at
 14 the end the following:

15 “(iii) Notwithstanding any other provisions of law,
 16 any hospital that was classified as a rural referral center
 17 under this subparagraph on September 30, 1994, shall
 18 continue to be classified as a rural referral center for fiscal
 19 year 1995 and each subsequent fiscal year with respect
 20 to payments under this title, unless the area in which the
 21 hospital is located is designated as an MSA for such fiscal
 22 year.”.

23 (2) PERMITTING HOSPITALS TO DECLINE RE-
 24 CLASSIFICATION.—If any hospital fails to comply as
 25 a rural referral center under section 1886(d)(5)(C)

1 as a result of a decision by the Medicare Geographic
 2 Classification Review Board under section
 3 1886(d)(10) to reclassify the hospital as being lo-
 4 cated in an urban area for fiscal year 1995 or fiscal
 5 year 1996, the Secretary of Health and Human
 6 Services shall—

7 (A) notify the hospital of the failure to
 8 qualify,

9 (B) provide an opportunity for the hospital
 10 to decline the reclassification, and

11 (C) if the hospital—

12 (i) declines the reclassification, admin-
 13 ister the Social Security Act (other than
 14 section 1886(d)(8)(D)) for such fiscal year
 15 as if the decision by the Review Board had
 16 not occurred, or

17 (ii) fails to decline the reclassification,
 18 administer the Social Security Act without
 19 regard to paragraph (1).

20 (b) GEOGRAPHIC RECLASSIFICATION AND GRAD-
 21 UATED AREA WAGE INDEX FOR RURAL REFERRAL CEN-
 22 TERS.—

23 (1) IN GENERAL.—Section 1886(d)(10)(D) (42
 24 U.S.C. 1395ww(d)(10)(D)) is amended by adding at
 25 the end the following new clauses:

1 “(iv) Notwithstanding clause (i) and section
 2 412.230(e)(1)(iii) of title 42, Code of Federal Regulations
 3 (relating to criteria for use of an area’s wage index), with
 4 respect to applications requesting a change in a hospital’s
 5 geographic classification pursuant to subparagraph
 6 (C)(i)(II) for fiscal year 1998 and subsequent fiscal years,
 7 the Secretary shall treat an eligible hospital (as defined
 8 in clause (v)) as if it were located in another area.

9 “(v) For purposes of clause (iv), an “eligible hos-
 10 pital” means a hospital that—

11 “(I) is classified as a rural referral center under
 12 paragraph (5)(C);

13 “(II) submits an application in accordance with
 14 this paragraph requesting a change in the hospital’s
 15 geographic classification pursuant to subparagraph
 16 (C)(i)(II); and

17 “(III) meets all other applicable requirements
 18 and standards except that the hospital’s average
 19 hourly wage (as determined by the Secretary) is less
 20 than 108 percent of the average hourly wage of the
 21 hospitals in the area in which the hospital is lo-
 22 cated.”.

23 (2) WAGE INDEX.—Section 1886(d)(8)(C) (42
 24 U.S.C. 1395ww(d)(8)(C)) is amended by adding at
 25 the end the following new clause:

1 “(v) Notwithstanding any other provision of
2 law—

3 “(I) in the case of an eligible hospital (as
4 defined in paragraph (10)(D)(iv) whose average
5 hourly wage (as determined by the Secretary) is
6 equal to or greater than 104 percent and less
7 than 108 percent of the average hourly wage of
8 the hospitals in the area in which the hospital
9 is located, the wage index for such hospital
10 shall be equal to the sum of—

11 “(aa) the wage index for the area in
12 which the hospital is located; and

13 “(bb) 66 percent of the difference be-
14 tween the wage index for the area to which
15 the hospital is reclassified (for a hospital
16 treated as if it were located in such area,
17 and the amount determined under item
18 (aa);

19 “(II) in the case of an eligible hospital
20 whose average hourly wage (as determined by
21 the Secretary) is greater than 100 percent and
22 less than 104 percent of the average hourly
23 wage of the hospitals in the areas in which the
24 hospital is located, the wage index of such hos-
25 pital shall be determined as if the reference in

1 subclause (I) to ‘66 percent’ were a reference to
 2 ‘33 percent’.”.

3 (c) EFFECTIVE DATE.—The amendments made by
 4 subsection (b) apply to applications submitted to the Medi-
 5 care Geographic Classification Review Board under sec-
 6 tion 1886(d)(10)(C) for reclassification in fiscal year
 7 1998, and for each subsequent application period.

8 **SEC. 11118. TELEMEDICINE.**

9 Title XVII of the Public Health Service Act (42
 10 U.S.C. 300u et seq.) is amended—

11 (1) in the title heading by striking out “AND
 12 HEALTH PROMOTION” and inserting “,
 13 HEALTH PROMOTION AND TELEMEDICINE
 14 DEVELOPMENT”;

15 (2) by inserting after the title heading the fol-
 16 lowing:

17 “PART A—HEALTH INFORMATION AND HEALTH
 18 PROMOTION”;

19 and

20 (3) by adding at the end the following:

21 “PART B—TELEMEDICINE DEVELOPMENT
 22 “GRANT PROGRAM FOR PROMOTING THE DEVELOPMENT
 23 OF RURAL TELEMEDICINE NETWORKS.

24 SEC. 1711. (a) ESTABLISHMENT.—The Secretary
 25 shall establish a program to award grants to eligible enti-

1 ties in accordance with this subsection to promote the de-
 2 velopment of rural telemedicine networks.

3 “(b) GRANTS FOR DEVELOPMENT OF RURAL TELE-
 4 MEDICINE.—The Secretary, acting through the Office of
 5 Rural Health Policy, shall award grants to eligible entities
 6 that have applications approved under subsection (d) for
 7 the purpose of expanding access to health care services
 8 for individuals in rural areas through the use of telemedi-
 9 cine. Grants shall be awarded under this section to—

10 “(1) encourage the initial development of rural
 11 telemedicine networks;

12 “(2) expand existing networks;

13 “(3) link existing networks together; or

14 “(4) link such networks to existing fiber optic
 15 telecommunications systems.

16 “(c) ELIGIBLE ENTITY DEFINED.—For the purposes
 17 of this section the term ‘eligibility entity’ means hospitals
 18 and other health care providers operating in a health care
 19 network of community-based providers that includes at
 20 least three of the following—

21 “(1) community or migrant health centers;

22 “(2) local health departments;

23 “(3) community mental health centers;

24 “(4) nonprofit hospitals;

1 “(5) private practice health professionals, in-
2 cluding rural health clinics; or

3 “(6) other publicly funded health or social serv-
4 ices agencies.

5 “(d) APPLICATION.—To be eligible to receive a grant
6 under this section an eligible entity shall prepare and sub-
7 mit to the Secretary an application at such time, in such
8 manner and containing such information as the Secretary
9 may require, including a description of—

10 “(1) the need of the entity for the grant;

11 “(2) the use to which the entity would apply
12 any amounts received under such grant;

13 “(3) the source and amount of non-Federal
14 funds that the entity will pledge for the project
15 funded under the grant; and

16 “(4) the long-term viability of the project and
17 evidence of the providers commitment to the net-
18 work.

19 “(e) PREFERENCE IN AWARDING GRANTS.—In
20 awarding grants under this section, the Secretary shall
21 give preference to applicants that—

22 “(1) are health care providers operating in
23 rural health care networks or that propose to form
24 such networks with the majority of the providers in

1 such networks being located in a medically under-
2 served area or health professional shortage area;

3 “(2) can demonstrate broad geographic cov-
4 erage in the rural areas of the State, or States in
5 which the applicant is located;

6 “(3) propose to use funds received under the
7 grant to develop plans for, or to establish, telemedi-
8 cine systems that will link rural hospitals and rural
9 health care providers to other hospitals and health
10 care providers;

11 “(4) will use the amounts provided under the
12 grant for a range of health care applications and to
13 promote greater efficiency in the use of health care
14 resources;

15 “(5) demonstrate the long-term viability of
16 projects through use of local matching funds (in
17 cash or in-kind); and

18 “(6) demonstrate financial, institutional, and
19 community support and the long-range viability of
20 the network.

21 “(f) USE OF AMOUNTS.—Amounts received under a
22 grant awarded under this section shall be utilized for the
23 development of telemedicine networks. Such amounts may
24 be used to cover the costs associated with the development
25 of telemedicine networks and the acquisition of telemedi-

1 cine equipment and modifications or improvements of tele-
2 communications facilities, including—

3 “(1) the development and acquisition through
4 lease or purchase of computer hardware and soft-
5 ware, audio and visual equipment, computer network
6 equipment, modification or improvements to tele-
7 communications transmission facilities, telecommuni-
8 cations terminal equipment, interactive video equip-
9 ment, data terminal equipment, and other facilities
10 and equipment that would further the purposes of
11 this section;

12 “(2) the provision of technical assistance and
13 instruction for the development and use of such pro-
14 gramming equipment or facilities;

15 “(3) the development and acquisition of instruc-
16 tional programming;

17 “(4) the development of projects for teaching or
18 training medical students, residents, and other
19 health professions students in rural training sites
20 about the application of telemedicine;

21 “(5) transmission costs, maintenance of equip-
22 ment, and compensation of specialists and referring
23 practitioners;

1 “(6) the development of projects to use tele-
 2 medicine to facilitate collaboration between health
 3 care providers; and

4 “(7) such other uses that are consistent with
 5 achieving the purposes of this section as approved by
 6 the Secretary.

7 “(g) PROHIBITED USE OF AMOUNTS.—Amounts re-
 8 ceived under a grant awarded under this section shall not
 9 be used for—

10 “(1) expenditures to purchase or lease equip-
 11 ment to the extent the expenditures would exceed
 12 more than 60 percent of the total grant funds; or

13 “(2) expenditures for indirect costs (as deter-
 14 mined by the Secretary) to the extent the expendi-
 15 tures would exceed more than 10 percent of the total
 16 grant funds.

17 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
 18 are authorized to be appropriated such sums as may be
 19 necessary to carry out this section.

20 “(i) DEFINITION.—For the purposes of this section,
 21 the term ‘rural health care network’ means a group of
 22 rural hospitals or other rural health care providers (includ-
 23 ing clinics, physicians, and nonphysicians primary care
 24 providers) that have entered into a relationship with each
 25 other or with nonrural hospitals and health care providers

1 for the purpose of strengthening the delivery of health care
 2 services in rural areas or specifically to improve their pa-
 3 tients' access to telemedicine services. At least 75 percent
 4 of hospitals and other health care providers participating
 5 in the network shall be located in rural areas.”.

6 **SEC. 11119. ESTABLISHMENT OF RURAL HEALTH OUT-**
 7 **REACH GRANT PROGRAM.**

8 Title III of the Public Health Service Act (42 U.S.C.
 9 241 et seq.) is amended by adding at the end the follow-
 10 ing:

11 “PART O—RURAL HEALTH OUTREACH GRANTS

12 “RURAL HEALTH OUTREACH GRANT PROGRAM.

13 “SEC. 3990 (a) IN GENERAL.—The Secretary may
 14 make grants to demonstrate the effectiveness of outreach
 15 to populations in rural areas that do not normally seek
 16 or do not have access to health or mental health services.
 17 Grants shall be awarded to enhance linkages, integration,
 18 and cooperation in order to provide health or mental
 19 health services, to enhance services, or increase access to
 20 or utilization of health or mental health services.

21 “(b) MISSION OF THE OUTREACH PROJECTS.—
 22 Projects funded under subsection (a) should be designed
 23 to facilitate the integration and coordination of services
 24 in or among rural communities in order to address the

1 needs of populations living in rural or frontier commu-
 2 nities.

3 “(c) COMPOSITION OF PROGRAM.—

4 “(1) CONSORTIUM ARRANGEMENT.—To be eli-
 5 gible to participate in the grant program established
 6 under subsection (a), an applicant entity shall be a
 7 consortium of three or more separate and distinct
 8 entities formed to carry out an outreach project
 9 under subsection (b).

10 “(2) CERTAIN REQUIREMENTS.—A consortium
 11 under paragraph (1) shall be composed of three or
 12 more public or private nonprofit health care or social
 13 service providers. Consortium members may include
 14 local health departments, community or migrant
 15 health centers, community mental health centers,
 16 hospitals or private practices, or other publicly fund-
 17 ed health or social service agencies.

18 “(d) AUTHORIZATION OF APPROPRIATIONS.—For the
 19 purpose of carrying out this section, there are authorized
 20 to be appropriated \$30,000,000 for fiscal year 1997, and
 21 such sums as may be necessary for each of the fiscal years
 22 1998 through 2001.”.

23 **SEC. 11120. MEDICARE-DEPENDENT, SMALL, RURAL HOS-**
 24 **PITAL PAYMENT EXTENSION.**

25 (a) SPECIAL TREATMENT EXTENDED.—

1 (1) PAYMENT METHODOLOGY.—Section
 2 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(g)) is
 3 amended—

4 (A) in clause (i), by striking “October 1,
 5 1994,” and inserting “October 1, 1994, or be-
 6 ginning on or after October 1, 1996, and before
 7 October 1, 2000,”;

8 (B) by striking “and” at the end of clause
 9 (ii)(I);

10 (C) by striking the period at the end of
 11 clause (ii)(II) and inserting a semicolon;

12 (D) by adding at the end of clause (ii) the
 13 following:

14 “(III) for discharges occurring during any cost
 15 reporting period beginning on or before October 1,
 16 1996, and before October 1, 2000, 50 percent of the
 17 amount by which the hospital’s target amount (as
 18 defined in subclause (IV)) for the cost reporting pe-
 19 riod exceeds the amount determined under para-
 20 graph (1)(A)(iii); and

21 “(IV) for purposes of subclause (III), a facili-
 22 ty’s target amount for the cost reporting period is
 23 as defined in subsection (b)(3)(D) except that the
 24 base cost reporting period shall be determined in ac-
 25 cordance with subsection (b)(3)(C)(v)(II), as amend-

ed in the Emergency Medicare Protection Act of 1996.”; and

(E) In clause (iv)—

(i) in subclause (III), by striking “and”,

(ii) in subclause (IV), by striking the period and inserting a comma, and

(iii) by adding at the end the following:

“(V) for cost reporting periods beginning on or after October 1, 1996, for which not less than 60 percent of its inpatient days or discharges during the cost reporting periods beginning in fiscal year 1992 and fiscal year 1993 were attributable to inpatients for which payments are made under this subsection.”.

(2) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking “September 30, 1994,” and inserting “September 30, 1994, and for cost reporting periods beginning on or after October 1, 1996, and before October 1, 2000,”;

1 (B) in clause (ii), by striking “and” at the
2 end;

3 (C) in clause (iii) by striking the period at
4 the end and inserting a comma; and

5 (D) by adding at the end the following new
6 clauses:

7 “(iv) with respect to discharges occurring dur-
8 ing fiscal year 1997, the target amount shall be de-
9 fined as the average of—

10 “(I) the allowable operating costs of inpa-
11 tient hospital services (as defined in subsection
12 (a)(4)) recognized under this title for the hos-
13 pital’s cost reporting period (if any) beginning
14 during fiscal year 1992 increased (in a
15 compounded manner) by the applicable percent-
16 age increases applied to such hospital under
17 this paragraph for cost reporting periods begin-
18 ning in fiscal year 1993 and for discharges oc-
19 ccurring in fiscal years 1994, 1995, and 1996,
20 and

21 “(II) the allowable operating costs of inpa-
22 tient hospital services (as defined in subsection
23 (a)(4)) recognized under this title for the hos-
24 pital’s cost reporting period (if any) beginning
25 during fiscal year 1993 increased (in a

1 compounded manner) by the applicable percent-
 2 age increase applied to such hospital for dis-
 3 charges occurring in fiscal years 1994, 1995,
 4 and 1996, and

5 “(v) with respect to discharges occurring during
 6 fiscal years 1998 through 2000, the target amount
 7 for the preceding year increased by the applicable
 8 percentage increase under subparagraph (B)(iv).”.

9 (3) PERMITTING HOSPITALS TO DECLINE RE-
 10 CLASSIFICATION.—Section 13501(e)(2) of OBRA–93
 11 (42 U.S.C. 1395ww note) is amended by striking
 12 “or fiscal year 1994” and inserting “, fiscal year
 13 1994, fiscal year 1995, fiscal year 1996, fiscal year
 14 1997, fiscal year 1998, or fiscal year 1999”.

15 (b) EFFECTIVE DATE.—The amendments made by
 16 subsection (a) apply with respect to discharges occurring
 17 during portions of cost reporting periods beginning on or
 18 after October 1, 1996.

19 **Subtitle B—Provisions Relating to** 20 **Part B**

21 **SEC. 11121. PAYMENTS FOR PHYSICIANS’ SERVICES.**

22 (a) ESTABLISHING UPDATE TO CONVERSION FACTOR
 23 TO MATCH SPENDING UNDER SUSTAINABLE GROWTH
 24 RATE.—

25 (1) UPDATE—

1 (A) IN GENERAL.—Section 1848(d)(3) (42
 2 U.S.C. 1395W–4(d)(3)) is amended to read as
 3 follows:

4 “(3) UPDATE.—

5 “(A) IN GENERAL.—Unless Congress oth-
 6 erwise provides, subject to subparagraph (D)
 7 and the budget-neutrality factor determined by
 8 the Secretary under subsection (c)(2)(B)(ii), the
 9 update to the single conversion factor estab-
 10 lished in paragraph (1)(C) for a year beginning
 11 with 1997 shall be determined as follows:

12 “(i) 1997.—The update for 1997
 13 shall be the Secretary’s estimate of the
 14 weighted average of the three separate up-
 15 dates that would otherwise occur were it
 16 not for the enactment of section 11121 of
 17 the Emergency Medicare Protection Act of
 18 1996.

19 “(ii) SUBSEQUENT YEARS.—The up-
 20 date for years beginning with 1998 shall
 21 be equal to the product of—

22 “(I) 1 plus the Secretary’s esti-
 23 mate of the percentage increase in the
 24 MEI (described in section 1842(i)(3))
 25 for the year (divided by 100, and

1 “(II) 1 plus the Secretary’s esti-
2 mate of the update adjustment factor
3 for the year (divided by 100),
4 minus 1 and multiplied by 100.

5 “(B) UPDATE ADJUSTMENT FACTOR.—The
6 ‘update adjustment factor’ for a year is equal to
7 the quotient (as estimated by the Secretary)
8 of—

9 “(i) the difference between (I) the
10 sum of the allowed expenditures for physi-
11 cians’ services furnished during each of the
12 fiscal years 1995 through the year in-
13 volved, and (II) the sum of the amount of
14 actual expenditures for physicians’ services
15 furnished during each of the fiscal years
16 1995 through the previous year, divided by

17 “(ii) the allowed expenditures for phy-
18 sicians’ services furnished during the fiscal
19 year.

20 “(C) DETERMINATION OF ALLOWED EX-
21 PENDITURES.—For purposes of subparagraph
22 (B), allowed expenditures for physicians’ serv-
23 ices shall be determined as follows (as esti-
24 mated by the Secretary):

1 “(i) 1995.—In the case of allowed ex-
 2 penditures for 1995, such expenditures
 3 shall be equal to actual expenditures for
 4 services furnished during fiscal year 1995.

5 “(ii) SUBSEQUENT YEARS.—In the
 6 case of allowed expenditures for 1996 and
 7 each subsequent year, such expenditures
 8 shall be equal to allowed expenditures for
 9 the previous fiscal year increased by the
 10 sustainable growth rate under subsection
 11 (f) for the fiscal year.

12 “(D) RESTRICTION ON VARIATION FROM
 13 MEDICARE ECONOMIC INDEX.—Notwithstand-
 14 ing the amount of the update adjustment factor
 15 determined under subparagraph (B), the update
 16 in the conversion factor under this paragraph
 17 for a year may not be—

18 “(i) greater than 1.03 plus the Sec-
 19 retary’s estimate of the percentage in-
 20 crease in the MEI (described in section
 21 1842(i)(3)) for the year (divided by 100),
 22 minus 1 and multiplied by 100, or

23 “(ii) less than 0.9175 plus the Sec-
 24 retary’s estimate of the percentage in-
 25 crease in the MEI (described in section

1 1842(i)(3)) for the year (divided by 100),
 2 minus 1 and multiplied by 100.”.

3 (B) EFFECTIVE DATE.—The amendments
 4 made by subparagraph (A) apply to physicians’
 5 services furnished on or after January 1, 1997.

6 (2) CONFORMING AMENDMENTS.—

7 (A) SECTION 1848(d)(2).—Section
 8 1848(d)(2)(A) (42 U.S.C. 1395w-4(d)(2)(A)) is
 9 amended—

10 (i) in the matter preceding clause

11 (i)—

12 (I) by striking “(or factors) in
 13 the conversion factor (or factors)”
 14 and inserting “in the conversion fac-
 15 tor”,

16 (II) by striking “(beginning with
 17 1991)” and inserting “(beginning
 18 with 1996)”, and

19 (III) by striking the second sen-
 20 tence,

21 (ii) by amending clause (ii) to read as
 22 follows:

23 “(ii) such factors as enter into the
 24 calculation of the update adjustment factor
 25 as described in paragraph (3)(B); and”,

1 (iii) by amending clause (iii) to read
 2 as follows:

3 “(iii) access to services.”,

4 (iv) by striking clauses (iv), (v), and
 5 (vi), and

6 (v) by striking the last sentence.

7 (B) SECTION 1848(d)(2)(B).—Section
 8 1848(d)(2)(B) (42 U.S.C. 1395w-4(d)(2)(B))
 9 is amended—

10 (i) by striking “and” at the end of
 11 clause (iii),

12 (ii) by striking the period at the end
 13 of clause (iv) and inserting “; and”, and

14 (iii) by adding at the end the follow-
 15 ing new clause:

16 “(v) changes in volume or intensity of
 17 services.”.

18 (C) REDESIGNATION OF SUBPARA-
 19 GRAPH.—Section 1848(d)(2) (42 U.S.C.
 20 1395w-4(d)(2)) is further amended—

21 (i) by striking subparagraphs (C),
 22 (D), and (E),

23 (ii) by redesignating subparagraph
 24 (F) as subparagraph (C), and

1 (iii) in subparagraph (C), as redesign-
 2 nated, by striking “(or updates) in the con-
 3 version factor (or factors)” and inserting
 4 “in the conversion factor”.

5 (b) REPLACEMENT OF VOLUME PERFORMANCE
 6 STANDARD WITH SUSTAINABLE GROWTH RATE.—

7 (1) IN GENERAL.—Section 1848(f) (42 U.S.C.
 8 1395w-4(f)) is amended by striking paragraphs (2)
 9 through (5) and inserting the following:

10 “(2) SPECIFICATION OF GROWTH RATE.—

11 “(A) FISCAL YEAR 1996.—The sustainable
 12 growth rate for all physicians’ services for fiscal
 13 year 1996 shall be equal to the product of—

14 “(i) 1 plus the Secretary’s estimate of
 15 the percentage increase in the MEI (de-
 16 scribed in section 1842(i)(3)) for 1996 (di-
 17 vided by 100),

18 “(ii) 1 plus the Secretary’s estimate of
 19 the percentage change (divided by 100) in
 20 the average number of individuals enrolled
 21 under this part (other than private plan
 22 enrollees) from fiscal year 1995 to fiscal
 23 year 1996,

24 “(iii) 1 plus the Secretary’s estimate
 25 of the projected percentage growth in real

gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 1 percentage point, and

“(iv) 1 plus the Secretary’s estimate of the percentage change (divided by 100) in expenditures for all physicians’ services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law (including the Emergency Medicare Protection Act of 1996), determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians’ services resulting from changes in the update to the conversion factor under subsection (d), minus 1 and multiplied by 100.

“(B) SUBSEQUENT YEARS.—The sustainable growth rate for all physicians’ services for fiscal year 1997 and each subsequent year shall be equal to the product of—

“(i) 1 plus the Secretary’s estimate of the percentage increase in the MEI for the fiscal year involved (described in section 1842(i)(3)) (divided by 100),

“(ii) 1 plus the Secretary’s estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from the previous fiscal year to the fiscal year involved,

“(iii) 1 plus the Secretary’s estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 1 percentage point, and

“(iv) 1 plus the Secretary’s estimate of the percentage change (divided by 100) in expenditures for all physicians’ services in the fiscal year (compared with the previous fiscal year) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians’ services resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

“(3) DEFINITIONS.—In this subsection:

“(A) SERVICES INCLUDED IN PHYSICIANS’ SERVICES.—The term ‘physicians’ services’ includes other items and services (such as clinical diagnostic laboratory test and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician’s office, but does not include services furnished to an eligible organization enrollee.

“(B) ELIGIBLE ORGANIZATION ENROLLEE.—The term ‘eligible organization enrollee’ means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title through an eligible organization with a contract under part C (and, through 2000, enrollment with an organization with a contract under section 1876(h)).”.

(2) CONFORMING AMENDMENTS.—Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended—

(A) in the heading, by striking “VOLUME PERFORMANCE STANDARD RATES OF INCREASE” and inserting “SUSTAINABLE GROWTH RATE”,

(B) in paragraph (1)—

1 (i) in the heading, by striking “VOL-
 2 UME PERFORMANCE STANDARD RATES OF
 3 INCREASE” and inserting “SUSTAINABLE
 4 GROWTH RATE”,

5 (ii) in subparagraph (a), in the matter
 6 preceding clause (i), by striking “perform-
 7 ance standard rates of increase” and in-
 8 serting “sustainable growth rate”, and

9 (iii) in subparagraph (A), by striking
 10 “HMO enrollees” each place it appears
 11 and inserting “eligible organization enroll-
 12 ees”,

13 (C) in subparagraph (B), by striking “per-
 14 formance standard rates of increase” and in-
 15 serting “sustainable growth rate”, and

16 (D) in subparagraph (C)—

17 (i) in the heading, by striking “PER-
 18 FORMANCE STANDARD RATES OF IN-
 19 CREASE” and inserting “SUSTAINABLE
 20 GROWTH RATE”,

21 (ii) in the first sentence, by striking
 22 “with 1991), the performance standard
 23 rates of increase” and all that follows
 24 through the first period and inserting
 25 “with 1997), the sustainable growth rate

1 for the fiscal year beginning in that year.”,
 2 and
 3 (iii) in the second sentence, by strik-
 4 ing “January 1, 1990, the performance
 5 standard rate of increase under subpara-
 6 graph (D) for fiscal year 1990” and insert-
 7 ing “January 1, 1997, the sustainable
 8 growth rate for fiscal year 1997”.

9 (c) ESTABLISHMENT OF SINGLE CONVERSION FAC-
 10 TOR FOR 1996.—

11 (1) IN GENERAL.—Section 1848(d)(1) (42
 12 U.S.C. 1395w-4(d)(1)) is amended—

13 (A) by redesignating subparagraph (C) as
 14 subparagraph (E), and

15 (B) by inserting after subparagraph (B)
 16 the following:

17 “(C) SPECIAL RULES FOR 1996.—The sin-
 18 gle conversion factor for 1996 under this sub-
 19 section shall be \$35.42 for all physicians’ serv-
 20 ices (other than services covered in subpara-
 21 graph (D)), except that during 1996, conversion
 22 factors shall be used for surgical services and
 23 nonsurgical services (as defined in subsection
 24 (j)(1)) at the levels otherwise established by the
 25 Secretary for such services.

“(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—If the Secretary establishes a separate relative value scale and conversion factor for anesthesia services for a year, the separate conversion factor for anesthesia services shall be updated from the conversion factor that applied for such services in the previous year—

“(i) for 1997, by the same percentage change as for the category of surgical services as defined in subsection (j)(1), and

“(ii) for 1998 and thereafter, by the same percentage change as would apply for all physicians’ services as determined under paragraph (3).”.

(2) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w-4) is amended—

(A) by striking “(or factors)” each place it appears in subsection (d)(1) (A) and (E)(ii) (as redesignated by paragraph (1)(A),

(B) in subsection (d)(1)(A), by striking “or updates”,

(C) in subsection (d)(1)(E)(ii) (as redesignated by paragraph (1)(A)), by striking “(or updates)”, and

1 (D) in subsection (i)(1)(C), by striking
 2 “conversion factors” and inserting “the conver-
 3 sion factor”.

4 **SEC. 11122. PRACTICE EXPENSE RELATIVE VALUE UNITS.**

5 (a) EXTENSION TO 1997.—Section 1848(c)(2)(E)(i)
 6 (42 U.S.C. 1395w-4(c)(2)(E)(i)) is amended—

7 (1) by striking “and” at the end of subclause
 8 (II),

9 (2) by striking the period at the end of sub-
 10 clause (III) and inserting “, and”, and

11 (3) by inserting at the end the following:

12 “(IV) 1997, by an additional 25 percent of
 13 such excess.”.

14 (b) CHANGE IN FLOOR ON REDUCTIONS AND SERV-
 15 ICES COVERED.—Clauses (ii) and (iii)(II) of section
 16 1848(c)(2)(E) (42 U.S.C. 1395w-4(c)(2)(E)) are each
 17 amended by inserting “(or 115 percent in the case of
 18 1997)” after “128 percent”.

19 **SEC. 11123. SINGLE FEE FOR SURGERY.**

20 (a) IN GENERAL.—Section 1848(a) (42 U.S.C.
 21 1395w-4(a)) is amended by adding at the end the follow-
 22 ing:

23 “(5) SINGLE FEE FOR SURGERY.—

24 “(A) GENERAL RULE.—Payment under
 25 this part for surgical services (as defined by the

1 Secretary under subsection (j)(1)), when a sep-
 2 arate payment is also made for the services of
 3 a physician or other practitioners acting as an
 4 assistant at surgery, may not (except as pro-
 5 vided in subparagraph (B)), when added to the
 6 separate payment made for the services of that
 7 other practitioner, exceed the amount that
 8 would be paid for the surgical services if a sepa-
 9 rate payment were not made for the services of
 10 that practitioner.

11 “(B) EXCEPTIONS.—The Secretary may
 12 specify surgery procedures or situations to
 13 which subparagraph (A) does not apply.”.

14 (b) CONFORMING AMENDMENT.—Section
 15 1848(g)(2)(D) (42 U.S.C. 1395w-4(g)(2)(D)) is amended
 16 by inserting “(or the lower amount under subsection
 17 (a)(5))” after “subsection (a)”.

18 (c) EFFECTIVE DATE.—The amendments made by
 19 this section apply to services furnished on or after Janu-
 20 ary 1, 1997.

21 **SEC. 11124. INCENTIVES TO CONTROL HIGH VOLUME FOR**
 22 **IN-HOSPITAL PHYSICIANS’ SERVICES.**

23 (a) IN GENERAL.—

1 (1) LIMITATIONS DESCRIBED.—Part B of title
 2 XVIII is amended by adding at the end the follow-
 3 ing:

4 **“SEC. 1849. INCENTIVES TO CONTROL HIGH VOLUME FOR**
 5 **IN-HOSPITAL PHYSICIANS’ SERVICES.**

6 “(a) SERVICES SUBJECT TO REDUCTION.—

7 “(1) DETERMINATION OF HOSPITAL-SPECIFIC
 8 PER ADMISSION RELATIVE VALUE.—Not later than
 9 October 1 of each year (beginning with 1998), the
 10 Secretary shall determine for each hospital—

11 “(A) the hospital-specific per admission
 12 relative value under subsection (b)(2) for the
 13 following year, and

14 “(B) whether such hospital-specific relative
 15 value is projected to exceed the allowable aver-
 16 age per admission relative value applicable to
 17 the hospital for the following year under sub-
 18 section (b)(1).

19 “(2) REDUCTION FOR SERVICES AT HOSPITALS
 20 EXCEEDING ALLOWABLE AVERAGE PER ADMISSION
 21 RELATIVE VALUE.—If the Secretary determines
 22 (under paragraph (1)) that a medical staff’s hos-
 23 pital-specific per admission relative value applicable
 24 to the medical staff for the year, the Secretary shall
 25 reduce (in accordance with subsection (c)) the

1 amount of payment otherwise determined under this
 2 part for each physician's service furnished during
 3 the year to an inpatient of the hospital by an indi-
 4 vidual who is a member of the hospital's medical
 5 staff.

6 “(3) TIMING OF DETERMINATION; NOTICE TO
 7 MEDICAL STAFFS AND CARRIERS.—Not later than
 8 October 1 of each year (beginning with 1998), the
 9 Secretary shall notify the medical executive commit-
 10 tee of each hospital (as set forth in the Standards
 11 of the Joint Commission on the Accreditation of
 12 Health Organizations) of the determinations made
 13 with respect to the medical staff under paragraph
 14 (1).

15 “(b) DETERMINATION OF ALLOWABLE AVERAGE
 16 PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPE-
 17 CIFIC PER ADMISSION RELATIVE VALUES.—

18 “(1) ALLOWABLE AVERAGE PER ADMISSION
 19 RELATIVE VALUES.—

20 “(A) URBAN HOSPITALS.—In the case of a
 21 hospital located in an urban area, the allowable
 22 average per admission relative value established
 23 under this subsection for 1999 and 2000 is
 24 equal to 125 percent and for years after 2000
 25 is 120 percent of the median of 1997 hospital-

1 specific per admission relative values deter-
 2 mined under paragraph (2) for all hospital
 3 medical staffs.

4 “(B) RURAL HOSPITALS.—In the case of a
 5 hospital located in a rural area, the allowable
 6 average per admission relative value established
 7 under this subsection for 1999 and each suc-
 8 ceeding year, is equal to 140 percent of the me-
 9 dian of the 1997 hospital-specific per admission
 10 relative values determined under paragraph (2)
 11 for all hospital medical staffs.

12 “(2) HOSPITAL-SPECIFIC PER ADMISSION REL-
 13 ATIVE VALUE.—

14 “(A) IN GENERAL.—The hospital-specific
 15 per admission relative value projected for a hos-
 16 pital (other than a teaching hospital) for a cal-
 17 endar year, shall be equal to the average per
 18 admission relative value (as determined under
 19 section 1848(c)(2)) for physicians’ services fur-
 20 nished to inpatients of the hospital by the hos-
 21 pital’s medical staff (excluding interns and resi-
 22 dents) during the second year preceding such
 23 calendar year, adjusted for variations in case-
 24 mix and disproportionate share status among

1 hospitals (as determined by the Secretary under
2 subparagraph (C)).

3 “(B) SPECIAL RULE FOR TEACHING HOS-
4 PITALS.—The hospital-specific relative value
5 projected for a teaching hospital in a calendar
6 year shall be equal to the sum of—

7 “(i) the average per admission relative
8 value (as determined under section
9 1848(c)(2)) for physicians’ services fur-
10 nished to inpatients of the hospital by the
11 hospital’s medical staff (excluding interns
12 and residents) during the second year pre-
13 ceding such calendar year, and

14 “(ii) the equivalent per admission rel-
15 ative value (as determined under section
16 1848(c)(2)) for physicians’ services fur-
17 nished to inpatients of the hospital by in-
18 terns and residents of the hospital during
19 the second year preceding such calendar
20 year, adjusted for variations in case-mix,
21 disproportionate share status, and teaching
22 status among hospitals (as determined by
23 the Secretary under subparagraph (C)).
24 The Secretary shall determine such equiva-
25 lent relative value unit per admission for

1 interns and residents based on the best
2 available data and may make such adjust-
3 ment in the aggregate.

4 “(C) ADJUSTMENT FOR TEACHING AND
5 DISPROPORTIONATE SHARE HOSPITALS.—The
6 Secretary shall adjust the allowable per admis-
7 sion relative values otherwise determined under
8 this paragraph to take into account the needs
9 of teaching hospitals and hospitals receiving ad-
10 ditional payments under subparagraphs (F) and
11 (G) of section 1886(d)(5). The adjustment for
12 teaching status or disproportionate share shall
13 not be less than zero.

14 “(c) AMOUNT OF REDUCTION.—The amount of pay-
15 ment otherwise made under this part for a physician’s
16 service that is subject to a reduction under subsection (a)
17 during a year shall be reduced 15 percent, in the case of
18 a service furnished by a member of the medical staff of
19 the hospital for which the Secretary determines under sub-
20 section (a)(1) that the hospital medical staff’s projected
21 relative value per admission exceeds the allowable average
22 per admission relative value.

23 “(d) RECONCILIATION OF REDUCTIONS BASED ON
24 HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION
25 WITH ACTUAL RELATIVE VALUES.—

1 “(1) DETERMINATION OF ACTUAL AVERAGE
2 PER ADMISSION RELATIVE VALUE.—Not later than
3 October 1 of each year (beginning with 2000), the
4 Secretary shall determine the actual average per ad-
5 mission relative value (as determined pursuant to
6 section 1848(c)(2)) for the physicians’ services fur-
7 nished by members of a hospital’s medical staff to
8 inpatients of the hospital during the previous year,
9 on the basis of claims for payment for such services
10 that are submitted to the Secretary not later than
11 90 days after the last day of such previous year. The
12 actual average per admission relative value shall be
13 adjusted by the appropriate case-mix, disproportion-
14 ate share factor, and teaching factor for the hospital
15 medical staff (as determined by the Secretary under
16 subsection (b)(2)(C)). Notwithstanding any other
17 provision of this title, no payment may be made
18 under this part for any physician’s service furnished
19 by a member of a hospital’s medical staff to an inpa-
20 tient of the hospital during a year unless such claim
21 is submitted to the Secretary for payment for such
22 service not later than 90 days after the last day of
23 the year.

24 “(2) RECONCILIATION WITH REDUCTIONS
25 TAKEN.—In the case of a hospital for which the pay-

1 ment amounts for physicians' services furnished by
2 members of the hospital's medical staff to inpatients
3 of the hospital were reduced under this section for
4 a year—

5 “(A) if the actual average per admission
6 relative value for such hospital's medical staff
7 during the year (as determined by the Secretary
8 under paragraph (1)) did not exceed the allow-
9 able average per admission relative value appli-
10 cable to the hospital's medical staff under sub-
11 section (b)(1) for the year, the Secretary shall
12 reimburse the fiduciary agent for the medical
13 staff by the amount by which payments for
14 such services were reduced for the year under
15 subsection (c), including interest at an appro-
16 priate rate determined by the Secretary; and

17 “(B) if the actual average per admission
18 relative value for such hospital's medical staff
19 during the year exceeded the allowable average
20 per admission relative value applicable to the
21 hospital's medical staff under subsection (a)(1)
22 for the year, the Secretary shall reimburse the
23 fiduciary agent for the medical staff the amount
24 withheld under subsection (c) multiplied by the
25 ‘final ratio’, including interest at an appropriate

1 rate determined by the Secretary. The final
 2 ratio described in the previous sentence shall be
 3 determined by dividing the difference between
 4 the initial ratio and 0.85, by 0.15, where the
 5 initial ratio is determined by dividing the medi-
 6 cal staff's allowable average per admission rel-
 7 ative value for a year (as determined under sub-
 8 section (a)(1)) by the medical staff's actual hos-
 9 pital-specific per admission relative value for
 10 such year, but in no case shall the initial ratio
 11 be less than 0.85.

12 “(3) MEDICAL EXECUTIVE COMMITTEE OF A
 13 HOSPITAL.—Each medical executive committee of a
 14 hospital whose medical staff is projected to exceed
 15 the allowable relative value per admission for a year,
 16 shall have one year from the date of notification that
 17 such medical staff is projected to exceed the allow-
 18 able relative value per admission to designate a fidu-
 19 ciary agent for the medical staff to receive and dis-
 20 burse any appropriate withhold amount made by the
 21 carrier.

22 “(4) ALTERNATIVE REIMBURSEMENT TO MEM-
 23 BERS OF STAFF.—At the request of a fiduciary
 24 agent for the medical staff, if the fiduciary agent for
 25 the medical staff is owed the reimbursement de-

1 scribed in paragraph (2)(B) for excess reductions in
 2 payments during a year, the Secretary shall make
 3 such reimbursement to the members of the hospital's
 4 medical staff, on a pro rata basis according to the
 5 proportion of expenditures for physicians' services
 6 furnished to inpatients of the hospital during the
 7 year that were furnished by each member of the
 8 medical staff.

9 “(e) DEFINITIONS.—In this section, the following
 10 definitions apply:

11 “(1) MEDICAL STAFF.—An individual furnish-
 12 ing a physician's service is considered to be on the
 13 medical staff of a hospital—

14 “(A) if (in accordance with requirements
 15 for hospitals established by the Joint Commis-
 16 sion on Accreditation of Health Organiza-
 17 tions)—

18 “(i) the individual is subject to by-
 19 laws, rules, and regulations established by
 20 the hospital to provide a framework for the
 21 self-governance of medical staff activities,

22 “(ii) subject to such bylaws, rules, and
 23 regulations, the individual has clinical
 24 privileges granted by the hospital's govern-
 25 ing body, and

1 “(iii) under such clinical privileges,
 2 the individual may provide physicians’
 3 services independently within the scope of
 4 the individual’s clinical privileges, or

5 “(B) if such physician provides at least one
 6 service to a Medicare beneficiary in such hos-
 7 pital.

8 “(2) RURAL AREA; URBAN AREA.—The terms
 9 ‘rural area’ and ‘urban area’ have the meaning given
 10 such terms under section 1886(d)(2)(D).

11 “(3) TEACHING HOSPITAL.—The term ‘teaching
 12 hospital’ means a hospital which has a teaching pro-
 13 gram approved as specified in section 1861(b)(6).

14 “(4) HOSPITAL.—The term ‘hospital’ means a
 15 subsection (d) hospital as defined in section 1886(d).

16 “(5) PHYSICIANS’ SERVICES.—The term ‘physi-
 17 cians’ services’ means those services described in
 18 section 1848(j)(3).”.

19 (2) CONFORMING AMENDMENTS.—

20 (A) SECTION 1833(a).—Section
 21 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is
 22 amended by inserting “subject to reduction
 23 under section 1849)” after “1848(a)(1)”.

24 (B) SECTION 1848(a).—Section
 25 1848(a)(1)(B) (42 U.S.C. 1395w-4(a)(1)(B)) is

1 amended by striking “this subsection,” and in-
 2 serting “this subsection and section 1849,”.

3 (b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL
 4 AT WHICH SERVICE FURNISHED.—Section
 5 1848(g)(4)(A)(i) (42 U.S.C. 1395w-4(g)(A)(i)) is amend-
 6 ed by striking “beneficiary,” and inserting “beneficiary
 7 (and, in the case of a service furnished to an inpatient
 8 of a hospital, report the hospital identification number on
 9 such claim form),”.

10 (c) EFFECTIVE DATES.—

11 (1) SUBSECTION (a).—The amendments made
 12 by subsection (a) apply to services furnished on or
 13 after January 1, 1999.

14 (2) SUBSECTION (b).—The amendments made
 15 by subsection (b) apply to services furnished on or
 16 after January 1, 1998.

17 **11125. AMBULATORY SURGICAL CENTER SERVICE UP-**
 18 **DATES.**

19 Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is
 20 amended—

21 (1) by striking “a fiscal year (beginning with
 22 fiscal year 1996)” and inserting “fiscal year 1996,
 23 and for other fiscal years beginning with 2003”, and

24 (2) by inserting after the subparagraph des-
 25 ignation “(C)” the following: “Notwithstanding the

1 second sentence of subparagraph (A) or the second
 2 sentence of subparagraph (B), with respect to fiscal
 3 years 1997 through 2002, the Secretary shall in-
 4 crease amounts for facility services by the percent-
 5 age increase in the Consumer Price Index for all
 6 urban consumers (United States city average) as es-
 7 timated by the Secretary for the 12-month period
 8 ending with the midpoint of the year involved, re-
 9 duced by two percentage points for fiscal years 1997
 10 through 2002.”.

11 **SEC. 11126. OXYGEN AND OXYGEN EQUIPMENT, OTHER DU-**
 12 **RABLE MEDICAL EQUIPMENT AND**
 13 **ORTHOTICS AND PROSTHETICS.**

14 (a) IN GENERAL.—

15 (1) FREEZE IN UPDATE FOR COVERED
 16 ITEMS.—Section 1834(a)(14) (42 U.S.C.
 17 1395m(a)(14)) is amended—

18 (A) by striking “and” at the end of sub-
 19 paragraph (A),

20 (B) in subparagraph (B)—

21 (i) by striking “a subsequent year”
 22 and inserting “1993, 1994, 1995, and
 23 1996”, and

24 (ii) by striking the period at the end
 25 and adding “; and”, and

1 (C) by adding at the end the following:

2 “(C) for each of the years 1997 through
3 2002, 0 percent; and

4 “(D) for a subsequent year, the percentage
5 increase in the Consumer Price Index for all
6 urban consumers (United States urban average)
7 for the 12-month period ending with June of
8 the previous year.”.

9 (2) UPDATE FOR ORTHOTICS AND PROSTHET-
10 ICS.—Section 1834(h)(4)(A) (42 U.S.C.
11 1395m(h)(4)(A)) is amended—

12 (A) in clause (i), by striking the comma at
13 the end and inserting a semicolon,

14 (B) by striking “and” at the end of clause
15 (iii) and inserting a semicolon, and

16 (C) by redesignating clause (iv) as clause
17 (v), and by adding after clause (iii), the follow-
18 ing clause:

19 “(iv) for 1996, 3.0 percent, and for
20 1997 through 2002, 0 percent, and”

21 (b) OXYGEN AND OXYGEN EQUIPMENT.—Section
22 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

23 (1) by striking “and” at the end of clause (iii);

24 (2) in clause (iv)—

1 (A) by striking “a subsequent year” and
 2 inserting “1993, 1994, 1995, and 1996”; and

3 (B) by striking the period at the end and
 4 inserting “; and”; and

5 (3) by adding at the end the following new
 6 clause:

7 “(v) in each subsequent year, is 90 percent
 8 of the national limited monthly payment rate
 9 computed under subparagraph (B) for the item
 10 for the year.”.

11 **SEC. 11127. ELIMINATION OF FORMULA-DRIVEN OVERPAY-**
 12 **MENTS FOR CERTAIN OUTPATIENT HOSPITAL**
 13 **SERVICES.**

14 (a) IN GENERAL.—Subparagraph (B)(i)(II) of sec-
 15 tion 1833(i)(3) (42 U.S.C. 1395l(i)(3)) and subparagraph
 16 (B)(i)(II) of section 1833(n)(1) (42 U.S.C. 1395l(n)(1))
 17 are each amended—

18 (1) by striking “of 80 percent”; and

19 (2) by striking the period at the end and insert-
 20 ing the following: “, less the amount a provider may
 21 charge as described in clause (ii) of section
 22 1866(a)(2)(A).”.

23 (b) EFFECTIVE DATE.—The amendments made by
 24 this section are effective for services furnished during por-

tions of cost reporting periods occurring on or after October 1, 1996.

SEC. 11128. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking “1992 through 1998” and inserting “beginning with 1992”.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking “1991 through 1998” and inserting “beginning with 1991”.

SEC. 11129. PROSPECTIVE PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

“(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

“(1) IN GENERAL.—Notwithstanding any other provision of this title, with respect to hospital outpatient services designated by the Secretary and furnished during years beginning with January 1, 2002, the amount of payment made for the services determined under this part shall be determined

1 under a prospective payment system established by
2 the Secretary in accordance with this subsection.

3 “(2) SYSTEM REQUIREMENTS.—Under the sys-
4 tem established by the Secretary under this sub-
5 section—

6 “(A) the Secretary shall develop a classi-
7 fication system to reflect the hospital outpatient
8 services furnished under this part;

9 “(B) groups of procedures and visits shall
10 be established so that procedures and visits
11 within each group are comparable clinically and
12 with respect to the use of resources;

13 “(C) the Secretary shall, using data from
14 the most recent year available, established rel-
15 ative payment weights for groups based on me-
16 dian hospital costs and shall determine the fre-
17 quency of each group;

18 “(D) the Secretary shall determine a wage
19 adjustment factor to adjust for relative dif-
20 ferences in labor and labor-related costs across
21 geographic regions;

22 “(E) the Secretary shall establish other ad-
23 justments as determined to be necessary to en-
24 sure equitable payments, such as outlier adjust-

1 ments or adjustments for certain classes of hos-
2 pitals; and

3 “(F) the Secretary shall examine potential
4 methodologies to control for unnecessary in-
5 creases in the volume of the services subject to
6 payment under this section.

7 “(3) GROUP PRICES.—On the basis of the
8 weights and frequencies described in paragraph
9 (2)(C), the Secretary shall establish prices for each
10 group such that 20 percent of the sum of the group
11 prices (taking into account appropriate adjustments
12 described in paragraph (2)(D) and paragraph
13 (2)(E)), multiplied by the frequencies, shall equal
14 the coinsurance target determined in paragraph (4).

15 “(4) COINSURANCE TARGET.—For purposes of
16 determining the group prices in paragraph (3), the
17 coinsurance target shall equal the Secretary’s esti-
18 mate of the projected total amount of coinsurance
19 payments that would be made under this part with
20 respect to outpatient hospital services furnished dur-
21 ing 2002 (without regard to the provisions of this
22 section) as determined under section
23 1866(a)(2)(A)(ii).

24 “(5) COINSURANCE AMOUNTS.—Beginning in
25 2002, the amount of coinsurance on hospital out-

1 patient services shall be calculated as 20 percent of
 2 the group price determined under paragraph (3), ad-
 3 justed for relative differences in the cost of labor
 4 and adjusted for other factors determined by the
 5 Secretary.

6 “(6) MEDICARE’S PAYMENT AMOUNT.—

7 “(A) IN GENERAL.—The Secretary shall—

8 “(i) establish an expenditure target
 9 based on an estimate of total projected
 10 Medicare payments made to hospitals for
 11 outpatient department services in 2002
 12 without regard to the provisions of this
 13 section; and

14 “(ii) determine a Medicare payment
 15 factor which when applied to the sum of
 16 the group prices (taking into account ap-
 17 propriate adjustments described in para-
 18 graph (2)(D) and paragraph (2)(E)) multi-
 19 plied by projected frequencies in 2002 shall
 20 equal the expenditure target.

21 “(B) 2002 AND THEREAFTER.—Beginning
 22 on January 1, 2002, the amount of payment
 23 made for outpatient department services shall
 24 be equal to the applicable group price, adjusted
 25 for differences in the cost of labor and adjusted

1 for other factors determined by the Secretary,
 2 multiplied by the Medicare payment factor.

3 “(7) UPDATES.—

4 “(A) IN GENERAL.—Beginning on January
 5 1, 2003, and until such time as the Medicare
 6 payment factor is 0.80, the Medicare payment
 7 factor shall be increased each year by the per-
 8 centage increase applicable under section
 9 1886(b)(3)(B)(iii) for the fiscal year in which
 10 the year begins.

11 “(B) RULE FOR UPDATES AFTER MEDI-
 12 CARE PAYMENT FACTOR BECOMES 0.80.—Dur-
 13 ing and after the first calendar year following
 14 the date on which the Medicare payment factor
 15 is 0.80—

16 “(i) the Medicare payment factor shall
 17 be frozen; and

18 “(ii) the group price shall be increased
 19 each year by the percentage increase appli-
 20 cable under section 1886(b)(3)(B)(iii) for
 21 the fiscal year in which the year begins.

22 “(8) PERIODIC REVIEW AND ADJUSTMENTS TO
 23 GROUP PRICES.—

24 “(A) PERIODIC REVIEW.—The Secretary
 25 may periodically review and revise the groups,

the relative payment weights, and the wage and other adjustments described in paragraph (2) and the group prices described in paragraph (3) to take into account changes in medical practice, changes in technology, the addition of new procedures, new cost data and other relevant information and factors.

“(B) BUDGET NEUTRALITY FOR ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then such adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if such adjustments has not been made.”.

(b) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A) Section 1833(i)(3)(A) (42 U.S.C. 1395l(i)(3)(A)) is amended by inserting “before January 1, 2002” after “furnished” and by striking “in a cost reporting period”.

(B) Section 1833(a)(4) (42 U.S.C. 1395l(a)(4)) is amended by deleting the semi-

1 colon following “subsection (i)” and inserting
 2 “or subsection (t);”.

3 (2) RADIOLOGY AND OTHER DIAGNOSTIC PRO-
 4 CEDURES.—

5 (A) Section 1833(n)(1)(A) (42 U.S.C.
 6 1395l(n)(1)(A)) is amended by inserting “and
 7 before January 1, 2002” after “October 1,
 8 1988,” and after “October 1, 1989,”.

9 (B) Section 1833(a)(2)(E) (42 U.S.C.
 10 1395l(a)(2)(E)) is amended by deleting the
 11 semicolon following “subsection (n)” and insert-
 12 ing “or (t);”.

13 (3) OTHER HOSPITAL OUTPATIENT SERV-
 14 ICES.—Section 1833(a)(2)(B) (42 U.S.C.
 15 1395l(a)(2)(B)) is amended—

16 (A) in clause (i), by inserting “before Jan-
 17 uary 1, 2002,” after “(i);”;

18 (B) in clause (ii), by inserting “before Jan-
 19 uary 1, 2002,” after “(ii);”;

20 (C) by redesignating clause (iii) as clause
 21 (iv); and

22 (D) by striking “or” at the end of clause
 23 (ii) and inserting the following new clause:

1 “(iii) on or after January 1, 2002, the
 2 amount determined under subsection (t),
 3 or”.

4 (4) COINSURANCE.—Section 1866(a)(2)(A)(ii)
 5 (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by add-
 6 ing at the end the following new sentence: “In the
 7 case of items and services for which payment is
 8 made under part B under the prospective payment
 9 system established under section 1833(t), clause (ii)
 10 of the first sentence shall be applied by substituting
 11 for 20 percent of the reasonable charge, the applica-
 12 ble coinsurance amount established under such sys-
 13 tem.”.

14 **SEC. 11130. WAIVE COST-SHARING FOR MAMMOGRAPHY.**

15 (a) DIAGNOSTIC MAMMOGRAPHY.—Section 1861(s)
 16 (42 U.S.C. 1395x(s)) is amended—

17 (1) in paragraph (3), by striking “including di-
 18 agnostic mammography if conducted by a facility
 19 that has a certificate (or provisional certificate) is-
 20 sued under section 354 of the Public Health Service
 21 Act”,

22 (2) by striking “and” at the end of paragraph
 23 (15),

24 (3) by striking the period at the end of para-
 25 graph (16) and inserting “; and”, and

1 (4) by adding at the end the following:

2 “(17) diagnostic mammography, if conducted
3 by a facility that has a certificate (or provisional cer-
4 tificate) issued under section 354 of the Public
5 Health Service Act.”.

6 (b) PAYMENT FOR SCREENING MAMMOGRAPHY.—
7 Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is
8 amended by striking “, subject to the deductible estab-
9 lished under section 1833(b),” and “80 percent of”.

10 (c) WAIVER OF DEDUCTIBLE.—The first sentence of
11 section 1833(b) (42 U.S.C. 1395l(b)) is amended—

12 (1) by striking “and” before “(4)”, and

13 (2) by inserting the following before the period
14 at the end: “, and (5) such deductible shall not
15 apply with respect to screening and diagnostic mam-
16 mography described in section 1861(s)(13) and sec-
17 tion 1861(s)(17)”.

18 (d) WAIVER OF COINSURANCE.—Section 1833(a)(1)
19 (42 U.S.C. 1395l(a)(1)) is amended—

20 (1) by striking “and” at the end of subpara-
21 graph (O), and

22 (2) by inserting before the semicolon at the end
23 of subparagraph (P) the following “, and (Q) with
24 respect to diagnostic mammography described in
25 section 1861(s)(17), the amount paid shall be 100

1 percent of the fee schedule amount provided under
2 section 1848”.

3 (e) **WAIVER OF COINSURANCE IN HOSPITAL OUT-**
4 **PATIENT DEPARTMENTS.**—The third sentence of section
5 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by
6 inserting after “1861(s)(10)(A)” the following: “, with re-
7 spect to items and services described in section
8 1861(s)(13), with respect to items and services described
9 in section 1861(s)(17),”.

10 (f) **EFFECTIVE DATE.**—The amendments made by
11 the preceding subsections apply to services furnished on
12 or after January 1, 1997 through December 31, 2000.

13 **SEC. 11131. ANNUAL MAMMOGRAMS.**

14 (a) **PROVIDING ANNUAL SCREENING MAMMOGRAPHY**
15 **FOR WOMEN OVER AGE 49.**—Section 1834(c)(2)(A) (42
16 U.S.C. 1395m(c)(2)(A)) is amended—

17 (1) in clause (iv), by striking “but under 65
18 years of age,” and

19 (2) by striking clause (v).

20 (b) **EFFECTIVE DATE.**—The amendment made by
21 subsection (a) applies to services furnished on or after
22 January 1, 1997 through December 31, 2000.

23 **SEC. 11132. COVERAGE OF COLORECTAL SCREENING.**

24 (a) **IN GENERAL.**—Section 1834 (42 U.S.C. 1395m)
25 is amended by inserting after subsection (c) the following:

1 “(d) COVERAGE AND DEFINITION OF COLORECTAL
2 SCREENING PROCEDURES.—

3 “(1) IN GENERAL.—Notwithstanding any other
4 provision of this part, payment may be made only
5 for periodic colonoscopy screening procedures con-
6 ducted consistent with the frequency permitted
7 under this subsection.

8 “(2) FREQUENCY LIMITS FOR SCREENING
9 FECAL-OCCULT BLOOD TESTS.—Subject to revision
10 by the Secretary under paragraph (5), no payment
11 may be made under this part for a screening fecal-
12 occult blood test provided to an individual for the
13 purpose of early detection of colon cancer if the test
14 is performed—

15 “(A) in the case of an individual under 65
16 years of age, more frequently than is provided
17 in a periodicity schedule established by the Sec-
18 retary for purposes of this subparagraph, or

19 “(B) in the case of any other individual,
20 within the 11 months following the month in
21 which a previous screening fecal-occult blood
22 test was performed.

23 “(3) PERIODIC COLORECTAL SCREENING PRO-
24 CEDURES FOR INDIVIDUALS NOT AT HIGH RISK FOR
25 COLORECTAL CANCER.—

“(A) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (5), no payment may be made under this part for a periodic colorectal screening procedure provided to an individual for the purpose of early detection of colon cancer if the procedure is performed—

“(i) on an individual under 50 years of age; or

“(ii) within the 59 months after a previous periodic colorectal screening procedure.

“(B) PERIODIC COLORECTAL SCREENING PROCEDURE DEFINED.—The term ‘periodic colorectal screening procedure’ means a flexible sigmoidoscopy, barium enema screening procedure, or other screening procedure for colorectal cancer as determined by the Secretary.

“(4) SCREENING PROCEDURES FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

“(A) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (5), no payment may be made under this part for eligible procedures defined in subparagraph (B) for individuals at high risk for colorectal cancer for

the purpose of early detection of colon cancer if the procedure is performed within the 47 months following the month in which a previous eligible procedure was performed.

“(B) ELIGIBLE PROCEDURES.—Procedures eligible for payment under this part for screening for individuals at high risk for colorectal cancer for the purpose of early detection of colorectal cancer shall include a screening colonoscopy, barium enema screening procedures, or other screening procedures for colorectal cancer as the Secretary determines appropriate.

“(C) FACTORS CONSIDERED IN ESTABLISHING CRITERIA FOR DETERMINING INDIVIDUALS AT HIGH RISK.—In establishing criteria for determining whether an individual is at high risk for colorectal cancer for purposes of this paragraph, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

“(5) REVISION OF FREQUENCY.—

“(A) REVIEW.—The Secretary shall review periodically the appropriate frequency for per-

forming screening fecal-occult blood tests, screening flexible sigmoidoscopies, barium enema screening procedures, screening colonoscopies, and other colorectal screening procedures determined appropriate by the Secretary, based on age and such other factors as the Secretary believes to be pertinent.

“(B) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under subparagraph (a), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection.”.

(b) CONFORMING AMENDMENTS.—

(1) SECTION 1833(a).—Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by striking “subsection (h)(1),” and inserting “subsection (h)(1) or section 1834(d)(1),”.

(2) SECTION 1862(a).—Section 1862(a) (42 U.S.C. 1395y(a)) is amended)—

(A) in paragraph (1)—

(i) by striking “and” at the end of subparagraph (E),

1 (ii) by striking the semicolon at the
 2 end of subparagraph (F) and inserting “,
 3 and”, and

4 (iii) by adding at the end the follow-
 5 ing:

6 “(G) in the case of screening fecal-occult
 7 blood tests, screening flexible sigmoidoscopies,
 8 barium enema screening procedures, screening
 9 colonoscopies, and other colorectal screening
 10 procedures determined appropriate by the Sec-
 11 retary, provided for the purpose of early detec-
 12 tion of colon cancer, which are performed more
 13 frequently than is covered under section
 14 1834(d);”, and

15 (B) in paragraph (7), by striking “para-
 16 graph (1)(B) or under paragraph (1)(F)” and
 17 inserting “subparagraphs (B), (F), or (G) of
 18 paragraph (1)”.

19 (c) EFFECTIVE DATE.—The amendments made by
 20 the preceding subsections apply to services furnished on
 21 or after January 1, 1997 through December 31, 2000.

22 **SEC. 11133. PAYMENTS FOR VACCINES AND VACCINE AD-**
 23 **MINISTRATION.**

24 (a) PAYMENT AMOUNTS FOR THE ADMINISTRATION
 25 OF CERTAIN VACCINES.—

1 (1) IN GENERAL.—Section 1833(k) (42 U.S.C.
2 1395l(k)) is amended to read as follows:

3 “(k)(1) The payment amount under this part for the
4 administration of a vaccine described in section
5 1861(s)(10) shall be equal to—

6 “(A)(i) for a vaccine administered in 1997 not
7 in connection with the furnishing of another service,
8 \$9, and

9 “(ii) for a vaccine administered in 1997 in con-
10 nection with the furnishing of another service, \$4,
11 and

12 “(B) for a vaccine administered in any subse-
13 quent year, the amount determined under subpara-
14 graph (A), or under this subparagraph, for the pre-
15 vious year, increased by the update under section
16 1848(d)(3) for that subsequent year for physicians’
17 services (described in section 1848(d)(3)(A)(ii)(I)).

18 “(2) For a limitation on actual charges for items and
19 services described in section 1861(s)(10), see paragraphs
20 (1) and (2) of section 1848(g).”.

21 (2) CONFORMING AMENDMENT TO SECTION
22 1832(a)(1).—Section 1832(a)(1) (42 U.S.C.
23 1395k(a)(1)) is amended by striking “and (D)” and
24 inserting “, (D), and (K)”.

1 (3) CONFORMING AMENDMENTS TO SECTION
 2 1832(a)(2).—Section 1832(a)(2) (42 U.S.C.
 3 1395k(a)(2)) is amended—

4 (A) in subparagraph (B), by striking “de-
 5 scribed in subparagraph (G) or subparagraph
 6 (I)” and inserting “or services described in sub-
 7 paragraph (G), (I), or (K)”,

8 (B) in subparagraph (D), by inserting be-
 9 fore the semicolon the following: “, other than,
 10 in either case, services described in subpara-
 11 graph (K)”,

12 (C) in subparagraph (H), by inserting be-
 13 fore the semicolon the following: “, other than
 14 services described in subparagraph (K)”,

15 (D) in subparagraph (I), by striking the
 16 final “and”,

17 (E) in subparagraph (J), by striking the
 18 period and inserting “; and”, and

19 (F) by adding at the end the following:

20 “(K) administration of vaccines by provid-
 21 ers of services, or as rural health clinic or feder-
 22 ally qualified health center services.”.

23 (4) CONFORMING AMENDMENTS TO SECTION
 24 1833(a)(1).—Section 1833(a)(1)(B) (42 U.S.C.
 25 1395l(a)(1)(B)) is amended—

1 (A) by striking “items and services de-
 2 scribed” and inserting “vaccines listed”, and

3 (B) by inserting at the end the following:
 4 “and, with respect to the administration of
 5 those vaccines, the amounts described in sub-
 6 section (k)(1),”.

7 (5) CONFORMING AMENDMENTS TO SECTION
 8 1833(a)(42).—Section 1833(a)(2) (42 U.S.C.
 9 1395l(a)(2)) is amended—

10 (A) in the matter preceding subparagraph
 11 (A), by striking “and (I)” and inserting “, (I),
 12 and (K)”, and

13 (B) in the matter in subparagraph (A) pre-
 14 ceding clause (i), by striking “items and serv-
 15 ices described” and inserting “vaccines listed”.

16 (6) CONFORMING AMENDMENT TO SECTION
 17 1833(a)(3).—Section 1833(a)(3) (42 U.S.C.
 18 1395l(a)(3)) is amended by striking “items and
 19 services described” and inserting “vaccines listed”.

20 (7) CONFORMING AMENDMENTS TO SECTION
 21 1833(a)(6).—Section 1833(a)(6) (42 U.S.C.
 22 1395l(a)(6)) is amended—

23 (A) by inserting “other than services de-
 24 scribed in section 1832(a)(2)(K)” after “serv-
 25 ices”, and

1 (B) by striking “and”.

2 (8) CONFORMING AMENDMENT TO SECTION
3 1833(a)(7).—Section 1833(a)(7) (42 U.S.C.
4 1395l(a)(7)) is amended by striking the period and
5 inserting “; and”.

6 (9) CROSS REFERENCE.—Section 1833(a) (42
7 U.S.C. 1395l(a)) is amended by adding at the end
8 the following:

9 “(8) in the case of services described in section
10 1832(a)(2)(k), the amount described in subsection
11 (k)(1).”.

12 (10) CONFORMING AMENDMENT TO SECTION
13 1834(g).—Section 1834(g)(2) (42 U.S.C.
14 1395m(g)(2)) is amended by inserting “(other than
15 services described in section 1832(a)(2)(K))” after
16 “hospital services”.

17 (11) CONFORMING AMENDMENTS TO SECTION
18 1842(b).—

19 (A) INITIAL MATTER IN PARAGRAPH
20 (3)(B).—The matter in section 1842(b)(3)(B)
21 (42 U.S.C. 1395u(b)(3)(B)) preceding clause
22 (i) is amended by inserting “, where payment
23 under this part for a service is on a basis other
24 than a cost basis,” after “carrier, and”.

1 (B) PARAGRAPH (3)(B)(ii).—Section
 2 1842(b)(3)(B)(ii)(I) (42 U.S.C.
 3 1395u(b)(3)(B)(ii)(I)) is amended by inserting
 4 “(or other payment basis)” after “reasonable
 5 charge”.

6 (12) CONFORMING AMENDMENTS TO SECTION
 7 1848(g).—

8 (A) PARAGRAPH (1).—The first sentence of
 9 section 1848(g)(1) (42 U.S.C. 1395w-4(g)(1))
 10 is amended by inserting “, or items and services
 11 described in section 1861(s)(10),” after “serv-
 12 ice”.

13 (B) PARAGRAPH (2).—Section
 14 1848(g)(2)(C) (42 U.S.C. 1395w-4(g)(2)(C)) is
 15 amended by adding at the end the following:
 16 “For items and services described in section
 17 1861(s)(10) furnished in a year after 1994, the
 18 “limiting charge” shall be 115 percent of the
 19 applicable amount described in section
 20 1833(k)(1).”.

21 (b) ELIMINATION OF COINSURANCE AND DEDUCT-
 22 IBLE FOR HEPATITIS B VACCINE.—Section
 23 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)), the matter in
 24 subparagraph (A) of section 1833(a)(2) (42 U.S.C.
 25 1395l(a)(2)) preceding clause (i), section 1833(a)(3) (42

1 U.S.C. 1395l(a)(3)), paragraph (1) of the first sentence
 2 of section 1833(b) (42 U.S.C. 1395l(b)), and the third
 3 sentence of section 1866(a)(2)(A) (42 U.S.C.
 4 1395cc(a)(2)(A)) are each amended by striking
 5 “1861(s)(10)(A)” and inserting “1861(s)(10)”.

6 (c) REPEAL OF OBSOLETE PROVISIONS.—

7 (1) SOCIAL SECURITY ACT.—Section
 8 1861(s)(10)(A) (42 U.S.C. 1395x(s)(10)(A)) is
 9 amended by striking “, subject to section 4071(b) of
 10 the Omnibus Reconciliation Act of 1987,”.

11 (2) OBRA–1987.—Section 4071(b) of OBRA–
 12 1987 is repealed.

13 (d) EFFECTIVE DATE.—The amendments made by
 14 subsections (a) and (b) shall apply to services furnished
 15 on or after January 1, 1997 through December 31, 2000.

16 **SEC. 11134. DIABETES SCREENING BENEFITS.**

17 (a) DIABETES OUTPATIENT SELF-MANAGEMENT
 18 TRAINING SERVICES.—

19 (1) IN GENERAL.—Section 1861(s)(2) (42
 20 U.S.C. 1395x(s)(2)), is amended—

21 (A) by striking “and” at the end of sub-
 22 paragraph (N);

23 (B) by striking “and” at the end of sub-
 24 paragraph (O); and

1 (C) by inserting after subparagraph (O)
 2 the following new subparagraph:

3 “(P) diabetes outpatient self-management
 4 training services (as defined in subsection (pp));
 5 and”.

6 (2) DEFINITION.—Section 1861 (42 U.S.C.
 7 1395x) is amended by adding at the end the follow-
 8 ing new subsection:

9 “DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING
 10 SERVICES

11 “(pp)(1) The term ‘diabetes outpatient self-manage-
 12 ment training services’ means educational and training
 13 services furnished to an individual with diabetes by or
 14 under arrangements with a certified provider (as described
 15 in paragraph (2)(A)) in an outpatient setting by an indi-
 16 vidual or entity who meets the quality standards described
 17 in paragraph (2)(B), but only if the physician who is man-
 18 aging the individual’s diabetic condition certifies that such
 19 services are needed under a comprehensive plan of care
 20 related to the individual’s diabetic condition to provide the
 21 individual with necessary skills and knowledge (including
 22 skills related to the self-administrations of injectable
 23 drugs) to participate in the management of the individ-
 24 ual’s condition.

25 “(2) In paragraph (1)—

1 “(A) a ‘certified provider’ is an individual or
 2 entity that, in addition to providing diabetes out-
 3 patient self-management training services, provides
 4 other items or services for which payment may be
 5 made under this title; and

6 “(B) an individual or entity meets the quality
 7 standards described in this paragraph if the individ-
 8 ual or entity meets quality standards established by
 9 the Secretary, except that the individual or entity
 10 shall be deemed to have met such standards if the
 11 individual or entity meets applicable standards origi-
 12 nally established by the National Diabetes Advisory
 13 Board and subsequently revised by organizations
 14 who participated in the establishment of standards
 15 by such Board, or is recognized by the American Di-
 16 abetes Association as meeting standards for furnish-
 17 ing the services.”.

18 (3) CONSULTATION WITH ORGANIZATIONS IN
 19 ESTABLISHING PAYMENT AMOUNTS FOR SERVICES
 20 PROVIDED BY PHYSICIANS.—In establishing payment
 21 amounts under section 1848(a) of the Social Secu-
 22 rity Act for physicians’ services consisting of diabe-
 23 tes outpatient self-management training services, the
 24 Secretary of Health and Human Services shall con-
 25 sult with appropriate organizations, including the

1 American Diabetes Association, in determining the
 2 relative value for such services under section
 3 1848(c)(2) of such Act.

4 (b) BLOOD GLUCOSE MONITORS FOR INDIVIDUALS
 5 WITH DIABETES.—

6 (1) INCLUDING STRIPS AS DURABLE MEDICAL
 7 EQUIPMENT.—Section 1861(n) (42 U.S.C.
 8 1395x(n)) is amended by striking the semicolon in
 9 the first sentence and inserting the following: “and
 10 includes blood glucose monitors for individuals with
 11 diabetes without regard to whether the individual
 12 has Type I or Type II diabetes or to the individual’s
 13 use of insulin (as determined under standards estab-
 14 lished by the Secretary in consultation with the
 15 American Diabetes Association);”.

16 (2) PAYMENT FOR MONITORS BASED ON METH-
 17 ODOLOGY FOR INEXPENSIVE AND ROUTINELY PUR-
 18 CHASED EQUIPMENT.—Section 1834(a)(2)(A) of
 19 such Act (42 U.S.C. 1395m(a)(2)(A)) is amended—

20 (A) by striking “or” at the end of clause

21 (ii);

22 (B) by adding “or” at the end of clause

23 (iii); and

24 (C) by inserting after clause (iii) the fol-

25 lowing new clause:

1 “(iv) which is a blood-testing monitor
2 for an individual with diabetes,”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section apply to items and services furnished on or
5 after January 1, 1997 through December 31, 2000.

6 **SEC. 11135. RESPITE BENEFIT.**

7 (A) ENTITLEMENT.—Section 1832(a)(2) (42 U.S.C.
8 1395k(a)(2)), as amended by section 11133(a), is amend-
9 ed by—

10 (1) striking “and” at the end of subparagraph
11 (J),

12 (2) striking the period at the end of subpara-
13 graph (K) and inserting “; and”, and

14 (3) inserting at the end the following new sub-
15 paragraph:

16 “(L) respite services for no more than 32
17 hours each year.”.

18 (b) CONDITIONS AND LIMITATIONS ON PAYMENT.—

19 (1) PAYMENT RATE.—Section 1833(a)(2) (42
20 U.S.C. 1395l(a)(2)) is amended by—

21 (A) adding a new subparagraph (G) to
22 read as follows:

23 “(G)(i) with respect to respite services,
24 payment shall be made at a rate equal to \$7.50
25 per hour for 1996 and at a rate to be deter-

mined by the Secretary in subsequent years;
and

“(ii) notwithstanding any provisions of section 1861(v), in the case of respite services furnished by a home health agency (or other organization designated by the Secretary pursuant to regulations), payment to the agency or other organization for respite services may not exceed 100 percent of the hourly respite allowance times the number of hours of respite for which the agency authorizes payment.”.

(2) CONDITIONS OF PAYMENT.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended by—

(A) striking “and” at the end of subparagraph (E),

(B) striking the period at the end of subparagraph (F) and inserting “; and”, and

(C) inserting at the end the following new subparagraph:

“(G) In the case of respite services, the individual for whom payment is claimed is severely impaired due to irreversible dementia (the individual has scored three or more errors on the Short Portable Mental Status Question-

naire) and either needs assistance in at least one out of five activities of daily living (bathing, dressing, transferring, toileting, and eating) or in at least one out of four instrumental activities of daily living (meal preparation, medication management, money management, and telephoning), or needs constant supervision because of one or more behavioral problems, as defined by the Secretary.”.

(3) FAMILY DESIGNATION OF RESPITE SERVICES PROVIDER AND CARE GIVER.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended by adding at the end the following new sentences: “In the case of respite services that are the subject of the certification described in subparagraph (G), the entity or individual providing the care for which respite is sought shall designate a respite services caregiver either through a home health agency or (if the Secretary designates other organizations to provide or arrange for such services) other organization. The agency or organization shall determine the amount of respite entitlement remaining in the calendar year and inform the entity or individual of the extent to which respite services may be authorized. When services have been provided, the entity or indi-

1 vidual shall inform the agency or organization, which
 2 shall then make payment to the caregiver. Where ad-
 3 ditional payment is made on behalf of the bene-
 4 ficiary, the agency or organization shall assure that
 5 the entity or individual is informed of the limits ap-
 6 plicable to payments for such services. No payment
 7 may be made under this title for respite services if
 8 the per-hour charge to the patient for care by respite
 9 aides exceeds by more than \$2 the hourly rates es-
 10 tablished under this title.”.

11 (c) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x)
 12 is amended—

13 (1) in subsection (m)—

14 (A) by striking “and” at the end of para-
 15 graph (6);

16 (B) by adding “and” at the end of para-
 17 graph (7); and

18 (C) by inserting after paragraph (7) the
 19 following:

20 “(8) respite services as described in subsection
 21 (oo);”,

22 (2) in subsection (o)—

23 (A) by striking “and” at the end of para-
 24 graph (6);

1 (B) by adding “and” at the end of para-
 2 graph (7); and

3 (C) by inserting after paragraph (7) the
 4 following:

5 “(8) agrees to provide or arrange for respite
 6 services as described in subsection (oo);”, and

7 (3) by adding after subsection (nn) the follow-
 8 ing:

9 “RESPITE SERVICES; RESPITE AIDES; RESPITE

10 PROVIDERS

11 “(oo)(1) The term ‘respite services’ means temporary
 12 care provided to individuals who meet the requirements
 13 of section 1835(a)(2) for the purposes of ensuring periodic
 14 time-off for co-resident primary informal caregivers. Al-
 15 though respite providers may provide assistance with per-
 16 sonal care or household maintenance activities, their pri-
 17 mary function is to provide protective supervision for per-
 18 sons with Alzheimer’s and related dementias whose mem-
 19 ory, orientation, judgment, and reasoning abilities have
 20 become so impaired that, for safety’s sake, they require
 21 the constant attention or close physical proximity of an-
 22 other person at all or almost all hours of the day or night.

23 “(2) The term ‘respite aides’ means individuals who
 24 have been designated by the Secretary as qualified to act
 25 as caregivers for purposes of providing the services de-
 26 scribed in paragraph (1). Respite aides may be nurse aides

1 who meet the requirements of section 1819(b)(5), home
 2 health aides who meet the requirements of section
 3 1891(a)(3), or other individuals licensed by the State or
 4 recognized by the Secretary as having the skills necessary
 5 to provide such services.

6 “(3) The term ‘respite providers’ means organiza-
 7 tions identified by the Secretary in regulations as qualified
 8 to provide or arrange for respite services under this title.
 9 The Secretary may establish by regulation such require-
 10 ments for respite providers as the Secretary determines
 11 appropriate.”.

12 (d) PAYMENT FROM SUPPLEMENTARY MEDICAL IN-
 13 SURANCE TRUST FUND FOR RESPITE SERVICES FUR-
 14 NISHED TO INDIVIDUALS WITH ONLY HOSPITAL INSUR-
 15 ANCE COVERAGE.—Section 1812(a) (42 U.S.C. 1395d(a))
 16 is amended—

17 (1) by striking “and” at the end of paragraph
 18 (3),

19 (2) by striking the period at the end of para-
 20 graph (4) and inserting “; and”; and

21 (3) by inserting at the end the following new
 22 paragraph:

23 “(5) respite services, described in section
 24 1832(a)(2)(L), except that such services shall be

1 furnished under the Supplementary Medical Insur-
 2 ance Program.”.

3 (e) EFFECTIVE DATE.—The amendments made by
 4 this section shall be effective for services beginning in fis-
 5 cal year 2002.

6 **SEC. 11136. PAYMENTS TO PHYSICIAN ASSISTANTS, NURSE**
 7 **PRACTITIONERS, AND CLINICAL NURSE SPE-**
 8 **CIALISTS.**

9 (a) COVERAGE IN HOME AND AMBULATORY SET-
 10 TINGS IN WHICH A FACILITY OR PROVIDER FEE IS NOT
 11 BILLED FOR PHYSICIAN ASSISTANTS, NURSE PRACTI-
 12 TIONERS, AND CLINICAL NURSE SPECIALISTS.—Section
 13 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

14 (1) in clause (i)—

15 (A) by striking “or” at the end of sub-
 16 clause (II); and

17 (B) by inserting “or (IV) in a home or am-
 18 bulatory setting in which a facility or provider
 19 fee is not billed (as defined by the Secretary),”
 20 following “shortage area,”; and

21 (2) in clause (iii)—

22 (A) by striking “in a rural” and inserting
 23 “in (I) a rural”; and

24 (B) by inserting “, or (II) in a home or
 25 ambulatory setting in which a facility or pro-

1 vider fee is not billed (as defined by the Sec-
2 retary),” after “(as defined in 1886(d)(2)(D))”.

3 (b) PAYMENTS TO PHYSICIAN ASSISTANTS, NURSE
4 PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS IN
5 HOME AND AMBULATORY SETTINGS IN WHICH A FACIL-
6 ITY OR PROVIDER FEE IS NOT BILLED.—

7 (1) IN GENERAL.—Section 1833(r)(1) (42
8 U.S.C. 1395l(r)(1)) is amended by striking “clinical
9 nurse specialist services provided in a rural area)”
10 and inserting “clinical nurse specialist services”.

11 (2) CONFORMING AMENDMENTS.—

12 (A) Section 1842(b)(6)(C) (42 U.S.C.
13 1395u(b)(6)(C)) is amended by striking
14 “clauses (i), (ii), or (iv)” and inserting “clauses
15 (i) or (ii)”.

16 (B) Section 1861(s)(2)(K) (42 U.S.C.
17 1395x(s)(2)(k)) is amended—

18 (i) in clause (i), by inserting “and
19 such services and supplies furnished as an
20 incident to such services as would be cov-
21 ered under subparagraph (A) if furnished
22 as an incident to a physician’s professional
23 service,” after “are performed,”;

24 (ii) in clause (ii), by inserting “and
25 such services and supplies furnished as an

1 incident to such service as would be cov-
 2 ered under subparagraph (A) if furnished
 3 as an incident to a physician's professional
 4 service, and" after "are performed,";

5 (iii) in clause (iii), by striking ", and"
 6 at the end and inserting a period; and

7 (iv) by striking clause (iv).

8 (c) PAYMENT UNDER THE FEE SCHEDULE TO PHY-
 9 SICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINI-
 10 CAL NURSE SPECIALISTS IN HOME AND AMBULATORY
 11 SETTINGS IN WHICH A FACILITY OR PROVIDER FEE IS
 12 NOT BILLED.—

13 (1) PAYMENT.—Section 1842(b)(12)(A) (42
 14 U.S.C. 1395u(b)(12)(A)) is amended in the matter
 15 preceding clause (i) by striking "(i), (ii), or (iv)"
 16 and inserting "(i) and (ii)".

17 (2) TECHNICAL AMENDMENT.—Section
 18 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is
 19 amended in the matter preceding clause (i) by strik-
 20 ing "a physician assistants" and inserting "physi-
 21 cian assistants".

22 (d) EFFECTIVE DATE.—The amendments made by
 23 this section apply to services furnished on or after Janu-
 24 ary 1, 1997.

1 **Subtitle C—Provisions Relating to**
2 **Parts A and B**

3 **SEC. 11141. CENTERS OF EXCELLENCE.**

4 (a) IN GENERAL.—Title XVIII is amended by insert-
5 ing after section 1888 the following:

6 “CENTERS OF EXCELLENCE

7 “SEC. 1889. (a) IN GENERAL.—The Secretary shall
8 use a competitive process to contract with centers of excel-
9 lence for coronary artery bypass surgery or other heart
10 procedures, knee surgery, hip surgery, and such other
11 services as the Secretary determines to be appropriate.
12 Payment under this title shall be made for services subject
13 to such contracts on the basis of negotiated or all-inclusive
14 rates as follows:

15 “(1) COVERAGE OF URBAN AREA.—The center
16 shall cover services provided in an urban area (as
17 defined in section 1886(d)(2)(D)) for years begin-
18 ning with fiscal year 1997.

19 “(2) SAVINGS REQUIRED.—The amount of pay-
20 ment made by the Secretary to the center under this
21 title for services covered under the project shall be
22 less than the aggregate amount of the payments
23 that the Secretary would have made to the center for
24 such services had the project not been in effect.

1 “(3) TYPES OF SERVICES.—The Secretary shall
 2 make payments to the center on such a basis for the
 3 following services furnished to individuals entitled to
 4 benefits under this title:

5 “(A) Facility, professional, and services re-
 6 lating to the procedure.

7 “(B) Such other services as the Secretary
 8 and the center may agree to cover under the
 9 agreement.”.

10 (b) EFFECTIVE DATE.—The amendments made by
 11 subsection (a) apply to services furnished on or after Octo-
 12 ber 1, 1996.”.

13 **SEC. 11142. MAINTAINING SAVINGS RESULTING FROM TEM-**
 14 **PORARY FREEZE ON PAYMENT INCREASES**
 15 **FOR HOME HEALTH SERVICES.**

16 (a) BASING UPDATES TO PER VISIT COST LIMITS ON
 17 LIMITS FOR FISCAL YEAR 1993.—Section
 18 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is
 19 amended by adding at the end the following sentence: “In
 20 establishing limits under this subparagraph, the Secretary
 21 may not take into account any changes in the costs of
 22 the provision of services furnished by home health agencies
 23 with respect to cost reporting periods which began on or
 24 after July 1, 1994, and before October 1, 1996.”.

1 (b) NO EXCEPTIONS PERMITTED BASED ON AMEND-
 2 MENT.—The Secretary of Health and Human Services
 3 shall not consider the amendment made by subsection (a)
 4 in making any exemptions and exceptions pursuant to sec-
 5 tion 1861(v)(1)(L)(ii) (42 U.S.C. 1395x(v)(1)(L)(ii)) of
 6 the Social Security Act.

7 **SEC. 11143. INTERIM PAYMENTS FOR HOME HEALTH SERV-**
 8 **ICES.**

9 (a) REDUCTIONS IN COST LIMITS.—Section
 10 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amend-
 11 ed—

12 (1) by inserting “and before October 1, 1996,”
 13 after “July 1, 1987” in subclause (III),

14 (2) by striking the period at the end of the
 15 matter following subclause (III), and inserting “,
 16 and”, and

17 (3) by adding at the end the following new sub-
 18 clause:

19 “(IV) October 1, 1996, 105 percent of the
 20 median of the labor-related and nonlabor per
 21 visit costs for freestanding home health agen-
 22 cies.”.

23 (b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii)
 24 (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking
 25 “July 1, 1996” and inserting “October 1, 1996”.

1 (c) ADDITIONS TO COST LIMITS.—Section
2 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by
3 adding at the end the following:

4 “(iv) For services furnished by home health agencies
5 for cost reporting periods beginning on or after October
6 1, 1996, but before October 1, 1999, the Secretary shall
7 provide for an interim system of limits. Payment shall be
8 the lower of—

9 “(I) costs determined under the preceding pro-
10 visions of this subparagraph, or

11 “(II) an agency-specific per beneficiary annual
12 limitation calculated from the agency’s 12-month
13 cost reporting period ending on or after January 1,
14 1994, and on or before December 31, 1994, based
15 on reasonable costs (including nonroutine medical
16 supplies), updated by the home health market basket
17 index. The per beneficiary limitation shall be multi-
18 plied by the agency’s unduplicated census count of
19 patients (entitled to benefits under this title) for the
20 year subject to the limitation to determine the ag-
21 gregate agency-specific per beneficiary limitation.

22 “(v) For services furnished by home health agencies
23 for cost reporting periods beginning on or after October
24 1, 1996, the following rules shall apply:

1 “(I) For new providers and those providers
2 without a 12-month cost reporting period ending in
3 calendar year 1994, the per beneficiary limitation
4 shall be equal to the mean of these limits (or the
5 Secretary’s best estimates thereof) applied to home
6 health agencies as determined by the Secretary.
7 Home health agencies that have altered their cor-
8 porate structure or name shall not be considered
9 new providers for payment purposes.

10 “(II) For beneficiaries who use services fur-
11 nished by more than one home health agency, the
12 per beneficiary limitations shall be prorated among
13 the agencies.

14 “(vi) Home health agencies whose cost or utilization
15 experience is below 125 percent of the mean national or
16 census region aggregate per beneficiary cost or utilization
17 experience for 1994, or best estimates thereof, and whose
18 year-end reasonable costs are below the agency-specific per
19 beneficiary limitation, shall receive payments equal to 50
20 percent of the difference between the agency’s reasonable
21 costs and its limit for fiscal years 1997, 1998, and 1999.
22 Such payments may not exceed 5 percent of such agency’s
23 aggregate Medicare reasonable cost in a year.

24 “(vii) Effective January 1, 1997, or as soon as fea-
25 sible, the Secretary shall modify the agency-specific per

1 beneficiary annual limitation described in clause (iv) to
2 provide for regional or national variations in utilization.
3 For purposes of determining payment under clause (iv),
4 the limit shall be calculated through a blend of 75 percent
5 of the agency-specific cost or utilization experience in
6 1994 with 25 percent of the national or census region cost
7 or utilization experience in 1994, or the Secretary's best
8 estimates thereof.”.

9 (d) USE OF INTERIM FINAL REGULATIONS.—The
10 Secretary of Health and Human Services (in this section
11 referred to as the “Secretary”) shall implement the pay-
12 ment limits described in section 1861(v)(1)(L)(iv) of the
13 Social Security Act by publishing in the Federal Register
14 a notice of interim final payment limits by August 1,
15 1996, and allowing for a period of public comment there-
16 on. Payments subject to these limits will be effective for
17 cost reporting periods beginning on or after October 1,
18 1996, without the necessity for consideration of comments
19 received, but the Secretary shall, by Federal Register no-
20 tice, affirm or modify the limits after considering those
21 comments.

22 (e) DEVELOPMENT OF CASE MIX SYSTEM.—The Sec-
23 retary shall expand research on a prospective payment sys-
24 tem for home health agencies that shall tie prospective
25 payments to an episode of care, including an intensive ef-

1 fort to develop a reliable case mix adjuster that explains
 2 a significant amount of the variances in costs.

3 (f) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—
 4 Effective for cost reporting periods beginning on or after
 5 October 1, 1997, the Secretary may require all home
 6 health agencies to submit such additional information as
 7 the Secretary considers necessary for the development of
 8 a reliable case mix system.

9 **SEC. 11144. PROSPECTIVE PAYMENT FOR HOME HEALTH**
 10 **SERVICES.**

11 Title XVIII is amended by adding at the end the fol-
 12 lowing:

13 “PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

14 “SEC. 1893. (a) IN GENERAL.—Notwithstanding sec-
 15 tion 1861(v), the Secretary shall, for cost reporting peri-
 16 ods beginning on or after October 1, 1999, provide for
 17 payments for home health services in accordance with a
 18 prospective payment system, which pays home health
 19 agencies on a per episode basis, established by the Sec-
 20 retary.

21 “(b) ELEMENTS OF SYSTEM.—Such a system shall
 22 include the following:

23 “(1) BASED ON A PER EPISODE AMOUNT.—All
 24 services covered and paid on a reasonable cost basis
 25 under the Medicare home health benefit as of the
 26 date of the enactment of the Emergency Medicare

1 Protection Act of 1996, including medical supplies,
2 shall be subject to the per episode amount. In defin-
3 ing an episode of care, the Secretary shall consider
4 an appropriate length of time for an episode, the use
5 of services, and the number of visits provided within
6 an episode, potential changes in the mix of services
7 provided within an episode and their cost, and a
8 general system design that will provide for continued
9 access to quality services. The per episode amount
10 shall be based on the most current audited cost re-
11 port data available to the Secretary.

12 “(2) USE OF CASE MIX.—The Secretary shall
13 employ an appropriate case mix adjustment that ex-
14 plains a significant amount of the variation in cost.

15 “(3) ANNUAL ADJUSTMENTS.—The episode
16 payment amount shall be adjusted annually by the
17 home health market basket index. The labor portion
18 of the episode amount shall be adjusted for geo-
19 graphic differences in labor-related costs based on
20 the most current hospital index.

21 “(4) OUTLIERS.—The Secretary may designate
22 a payment provision for outliers, recognizing the
23 need to adjust payments due to unusual variations
24 in the type or amount of medically necessary care.

1 “(5) PRORATION OF EPISODE PAYMENTS.—A
 2 home health agency shall be responsible for coordi-
 3 nating all home health care for a beneficiary. If a
 4 beneficiary elects to transfer to, or receive services
 5 from, another home health agency within an episode
 6 period, the episode payment shall be prorated be-
 7 tween home health agencies.

8 “(c) SAVINGS.—Prior to implementing the prospec-
 9 tive system described in subsections (a) and (b) in a budg-
 10 et-neutral fashion, the Secretary shall first reduce, by 15
 11 percent, the payments based on the cost limits, per bene-
 12 ficiary limits, and actual costs, described in section
 13 1861(v)(1)(L)(iv), as such limits are in effect on Septem-
 14 ber 30, 1999.”.

15 **SEC. 11145. PAYMENT BASED ON LOCATION WHERE HOME**
 16 **HEALTH SERVICE IS FURNISHED.**

17 (a) CONDITIONS OF PARTICIPATION.—Section 1891
 18 (42 U.S.C. 1395bbb) is amended by adding at the end
 19 the following:

20 “(g) A home health agency shall submit claims for
 21 payment of home health services under this title only on
 22 the basis of the geographic location at which the service
 23 is furnished, as determined by the Secretary.”.

1 (b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii)
 2 (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking
 3 “agency is located” and inserting “service is furnished”.

4 (c) EFFECTIVE DATE.—The amendments made by
 5 this section apply to services furnished on or after Janu-
 6 ary 1, 1997.

7 **SEC. 11146. ELIMINATION OF PERIODIC INTERIM PAY-**
 8 **MENTS FOR HOME HEALTH AGENCIES.**

9 (a) IN GENERAL.—Section 1815(e)(2) (42 U.S.C.
 10 1395g(e)(2)) is amended—

11 (1) by inserting “and” at the end of subpara-
 12 graph (C),

13 (2) by striking subparagraph (D), and

14 (3) by redesignating subparagraph (E) as (D).

15 (b) EFFECTIVE DATE.—The amendments made by
 16 subsection (a) apply to payments made on or after the
 17 implementation of prospective payments as described in
 18 section 1893 of the Social Security Act, as added by sec-
 19 tion 11144 of this Act.

20 **SEC. 11147. PERMANENT EXTENSION OF CERTAIN SECOND-**
 21 **ARY PAYER PROVISIONS.**

22 (a) WORKING DISABLED.—Section 1862(b)(1)(B)
 23 (42 U.S.C. 1395y(b)(1)(B)) is amended by striking clause
 24 (iii).

1 (b) INDIVIDUAL WITH END-STAGE RENAL DIS-
 2 EASE.—Section 1862(b)(1)(C) (42 U.S.C.
 3 1395y(b)(1)(C)) is amended—

4 (1) in the first sentence, by striking “12-
 5 month” each place it occurs and inserting “18-
 6 month”, and

7 (2) by striking the second sentence.

8 (c) IRS-SSA-HCFA DATA MATCH.—

9 (1) SOCIAL SECURITY ACT.—Section
 10 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is
 11 amended by striking clause (iii).

12 (2) INTERNAL REVENUE CODE.—Section
 13 6103(l)(12) of the Internal Revenue Code of 1986 is
 14 amended by striking subparagraph (F).

15 **Subtitle D—Medicare Part B** 16 **Premium**

17 **SEC. 11161. PART B PREMIUM.**

18 (a) IN GENERAL.—The first, second, and third sen-
 19 tences of section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) are
 20 amended to read as follows: “The Secretary shall, during
 21 September of each year, determine and promulgate a
 22 monthly premium rate for the succeeding calendar year.
 23 That monthly premium rate shall be equal to 50 percent
 24 of the monthly actuarial rate for enrollees age 65 and over,

1 determined according to paragraph (1), for that succeed-
 2 ing calendar year.”.

3 (b) CONFORMING AND TECHNICAL AMENDMENTS.—

4 Section 1839 (42 U.S.C. 1395r) is amended—

5 (1) in subsection (a)(2), by striking “(b) and
 6 (e)” and inserting “(b), (c), and (f)”,

7 (2) in the third sentence of subsection (a)(3),
 8 as amended by subsection (a) or this section—

9 (A) by inserting “rate” after “premium”,
 10 and

11 (B) by striking “and the derivation of the
 12 dollar amounts specified in this paragraph”,

13 (3) by striking subsection (e), and

14 (4) by redesignating subsection (g) as (e) and
 15 inserting that subsection after subsection (d).

16 (c) EFFECTIVE DATE.—The amendments made by
 17 this section apply to premiums for months after December
 18 1995.

19 **TITLE II—EXPANDED MEDICARE** 20 **CHOICE**

21 **SEC. 11201. EXPANDED CHOICE UNDER MEDICARE.**

22 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et
 23 seq.) is amended by inserting after section 1804 the fol-
 24 lowing:

1 “OPTION TO ENROLL IN MANAGED CARE PLANS

2 “SEC. 1805. Every individual entitled to benefits
3 under part A and enrolled under part B or enrolled under
4 part B only shall be eligible to enroll under part C with
5 any eligible organization with which the Secretary has en-
6 tered into a contract under part C and which serves the
7 geographic area in which the individual resides.”.

8 (b) EFFECTIVE DATE.—The amendment made by
9 subsection (a) applies to enrollments whose periods begin
10 after 1996.

11 **SEC. 11202. BROADER CHOICE AMONG MANAGED CARE OR-**
12 **GANIZATIONS.**

13 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et
14 seq.) is amended—

15 (1) by redesignating part C (42 U.S.C. 1395x
16 et seq.) as part D, and

17 (2) by inserting after part B the following new
18 part:

19 **“PART C—MANAGED CARE ORGANIZATIONS**

20 **“SEC. 1851A. TYPES OF MANAGED CARE ORGANIZATIONS.**

21 “(a) ELIGIBLE ORGANIZATIONS.—For purposes of
22 this part, the term ‘eligible organization’ means a public
23 or private entity, organized under the laws of any State,
24 that is—

1 “(1) a qualified health maintenance organiza-
2 tion (QHMO),

3 “(2) a competitive medical plan (CMP),

4 “(3) a preferred provider organization (PPO),

5 “(4) a provider sponsored organization (PSO),

6 or

7 “(5) any other managed care organization that
8 meets the requirements of subparagraphs (C), (D),
9 and (E) of subsection (c)(1) and any additional re-
10 quirements developed by the Secretary.

11 “(b) QUALIFIED HEALTH MAINTENANCE ORGANIZA-
12 TION (QHMO).—For purposes of this part, the term
13 ‘qualified health maintenance organization’ means such an
14 organization (as defined in section 1310(d) of the Public
15 Health Service Act) that meets the requirements of sub-
16 paragraphs (B) and (E) of subsection (c)(1).

17 “(c) COMPETITIVE MEDICAL PLAN (CMP).—

18 “(1) IN GENERAL.—For purposes of this part,
19 the term ‘competitive medical plan’ means an entity
20 that meets the following requirements:

21 “(A) MINIMUM SERVICES TO ALL MEM-
22 BERS.—The entity provides to enrolled mem-
23 bers at least the following health care services:

1 “(i) Physicians’ services performed by
 2 physicians (as defined in section
 3 1861(r)(1)).

4 “(ii) Inpatient hospital services.

5 “(iii) Laboratory, X-ray, emergency,
 6 and preventive services.

7 “(iv) Out-of-area coverage.

8 “(B) PROVISION OF PHYSICIANS’ SERV-
 9 ICES.—The entity provides physicians’ services
 10 primarily—

11 “(i) directly through physicians who
 12 are either employees or partners of such
 13 organization, or

14 “(ii) through contracts with individual
 15 physicians or one or more groups of physi-
 16 cians (organized on a group practice or in-
 17 dividual practice basis).

18 “(C) COMPENSATION ON PREPAID RISK
 19 BASIS.—The entity is compensated (except for
 20 deductibles, coinsurance, and copayments) for
 21 the provision of health care services to enrolled
 22 members by a payment which is paid on a peri-
 23 odic basis without regard to the date the health
 24 care services are provided and which is fixed
 25 without regard to the frequency, extent, or kind

1 of health care service actually provided to a
2 member.

3 “(D) ASSUMPTION OF RISK.—The entity
4 assumes full financial risk on a prospective
5 basis for the provision of the health care serv-
6 ices listed in subparagraph (A), except that
7 such entity may—

8 “(i) obtain insurance or make other
9 arrangements for the cost of providing to
10 any enrolled member health care services
11 listed in subparagraph (A) the aggregate
12 value of which exceeds \$5,000 in any year,

13 “(ii) obtain insurance or make other
14 arrangements for the cost of health care
15 services listed in subparagraph (A) pro-
16 vided to its enrolled members other than
17 through the entity because medical neces-
18 sity required their provision before they
19 could be secured through the entity,

20 “(iii) obtain insurance or make other
21 arrangements for not more than 90 per-
22 cent of the amount by which its costs for
23 any of its fiscal years exceed 115 percent
24 of its income for such fiscal year, and

1 “(iv) make arrangements with physi-
 2 cians or other health professionals, health
 3 care institutions, or any combination of
 4 such individuals or institutions to assume
 5 all or part of the financial risk on a pro-
 6 spective basis for the provision of basic
 7 health services by the physicians or other
 8 health professionals or through the institu-
 9 tions.

10 “(E) FISCAL SOUNDNESS; PROVISION
 11 AGAINST INSOLVENCY.—The entity meets
 12 standards for fiscal soundness (including stand-
 13 ards for provision against the risk of insol-
 14 vency) applicable to federally qualified health
 15 maintenance organizations under title XIII of
 16 the Public Health Service Act.

17 “(2) EXCEPTION FOR CERTAIN GRAND-
 18 FATHERED CONTRACTS.—Paragraph (1)(A)(ii) shall
 19 not apply to an entity which had contracted with a
 20 single State agency administering a State plan ap-
 21 proved under title XIX for the provision of services
 22 (other than inpatient hospital services) to individuals
 23 eligible for such services under such State plan on
 24 a prepaid risk basis prior to 1970.

1 “(d) PREFERRED PROVIDER ORGANIZATION
2 (PPO).—

3 “(1) IN GENERAL.—For purposes of this part,
4 the term ‘preferred provider organization’ means an
5 entity that meets the following requirements:

6 “(A) MINIMUM SERVICES TO ALL MEM-
7 BERS.—The entity provides at least physicians’
8 services performed by physicians (as defined in
9 section 1861(r)(1)).

10 “(B) PROVISION OF PHYSICIAN SERVICES;
11 FISCAL SOUNDNESS.—The entity meets the re-
12 quirements of subparagraphs (B) and (E) of
13 subsection (c)(1).

14 “(C) ASSUMPTION OF RISK.—The entity
15 meets the requirements of subsection (c)(1)(D)
16 with respect to members enrolled with the orga-
17 nization under this part.

18 “(2) DETERMINATION OF PRIVATE MEMBER-
19 SHIP.—In applying the provisions of sections
20 1851E(g) and 1851F (e)(1)(B)(i) and (f)(1)(B)(i)
21 (concerning minimum private enrollment) to an or-
22 ganization that meets the requirements of paragraph
23 (1), individuals for whom the organization has as-
24 sumed substantial financial risk shall be considered
25 to be members of the organization.

1 “(e) PROVIDER SPONSORED ORGANIZATION
2 (PSO).—

3 “(1) IN GENERAL.—For purposes of this part,
4 the term ‘provider sponsored organization’ means an
5 entity that meets the following requirements:

6 “(A) TYPE OF ENTITY.—The entity is a
7 hospital, a group of affiliated hospitals, or an
8 affiliated group consisting of a hospital or hos-
9 pitals and physicians or other entities that fur-
10 nish health services.

11 “(B) MINIMUM SERVICES TO ALL MEM-
12 BERS.—The entity provides at least physicians’
13 services performed by physicians (as defined in
14 section 1861(r)(1)) and inpatient hospital serv-
15 ices.

16 “(C) DIRECT PROVISION OF SERVICES.—
17 The entity provides directly a substantial por-
18 tion of the services covered under this title (as
19 determined by the Secretary, which may vary
20 for rural or underserved areas).

21 “(D) ASSUMPTION OF RISK.—The entity
22 meets the requirements of subsection (c)(1)(D)
23 with respect to members enrolled with the orga-
24 nization under this part.

1 “(E) FISCAL SOUNDNESS; PROVISION
2 AGAINST INSOLVENCY.—The entity meets re-
3 quirements for fiscal soundness and provision
4 against insolvency developed by the Secretary.

5 “(2) DETERMINATION OF PRIVATE MEMBER-
6 SHIP.—In applying the provisions of sections
7 1851E(g) and 1851F (e)(1)(B)(i) and (f)(1)(B)(i)
8 (concerning minimum private enrollment) to an or-
9 ganization that meets the requirements of paragraph
10 (1), individuals for whom the organization has as-
11 sumed substantial financial risk shall be considered
12 to be members of the organization.

13 “(3) PREEMPTION OF STATE LICENSURE RE-
14 QUIREMENTS.—Except as otherwise provided in the
15 next sentence, an organization that meets the re-
16 quirements of paragraph (1) may provide health
17 benefits to individuals enrolled with the organization
18 under this part without regard to any State law that
19 imposes requirements for licensure different from
20 the requirements for a contract under this part. If
21 the Secretary determines that a State has met the
22 criteria for participation in the alternative certifi-
23 cation and monitoring program described in section
24 1851H(b), the Secretary shall require the organiza-
25 tion to obtain a license from the State.

1 **“SEC. 1851B. ENROLLMENT AND DISENROLLMENT.**

2 “(a) IN GENERAL.—

3 “(1) SECRETARY’S RESPONSIBILITY.—The Sec-
4 retary shall carry out enrollment and termination of
5 enrollment of individuals with eligible organizations.

6 “(2) INDIVIDUAL OPTIONS.—An individual may,
7 as prescribed by regulations—

8 “(A) enroll under this part with an eligible
9 organization; and

10 “(B) terminate enrollment with such orga-
11 nization—

12 “(i) as of the beginning of the first
13 calendar month following the date on
14 which the request is made for such termi-
15 nation;

16 “(ii) as of the date determined in ac-
17 cordance with regulations, in the case of fi-
18 nancial insolvency of the organization; and

19 “(iii) retroactively to the date of en-
20 rollment, in such special circumstances as
21 the Secretary may designate.

22 “(b) INFORMATION CONCERNING ENROLLMENT.—

23 “(1) STANDARDIZED COMPARATIVE MATE-
24 RIALS.—The Secretary shall develop and distribute
25 standardized comparative materials about eligible or-
26 ganizations and Medicare supplemental policies (as

1 defined in section 1882(g)(1)) to enable individuals
2 to compare benefits, costs, and quality indicators.

3 “(2) COST-SHARING BY PARTICIPATING ORGANI-
4 ZATIONS.—Each eligible organization with a con-
5 tract under this part shall pay the Secretary for its
6 pro rata share (as determined by the Secretary) of
7 the estimated costs to be incurred by the Secretary
8 in carrying out the requirements of paragraph (1),
9 subsection (a)(1), and section 4360 of OBRA–1990.
10 Those payments are appropriated to defray the costs
11 described in the preceding sentence, to remain avail-
12 able until expended.

13 “(3) REVIEW OF MARKETING MATERIALS.—The
14 Secretary may prescribe the procedures and condi-
15 tions under which an eligible organization that has
16 entered into a contract with the Secretary under this
17 subsection may furnish information about the orga-
18 nization to enrollees and individuals eligible to enroll
19 under this part. No brochures, application forms, or
20 other promotional or informational material may be
21 distributed by an organization to (or for the use of)
22 such individuals unless at least 45 days before its
23 distribution, the organization has submitted the ma-
24 terial to the Secretary for review, and the Secretary
25 has not disapproved the distribution of the material.

1 The Secretary shall review all such material submit-
2 ted and shall disapprove such material if the Sec-
3 retary determines, in the Secretary's discretion, that
4 the material is materially inaccurate or misleading
5 or otherwise makes a material misrepresentation.

6 “(c) PERIODS OF ENROLLMENT.—

7 “(1) STANDARD ENROLLMENT OPPORTUNI-
8 TIES.—Subject to the provisions of this section, an
9 organization with a contract under this part shall
10 permit enrollment under this part by any individ-
11 ual—

12 “(A) during the month of each year speci-
13 fied by the Secretary for all eligible organiza-
14 tions;

15 “(B) during the individual's initial enroll-
16 ment period in the program under part B (as
17 described in section 1837(d));

18 “(C) during a special enrollment period in
19 the program under part B (for individuals for-
20 merly electing employment-based coverage) de-
21 scribed in section 1837(i)(3); and

22 “(D) during the 90-day period beginning
23 30 days before the date the individual takes up
24 residence in the service area of the organiza-
25 tion.

1 “(2) SPECIAL ENROLLMENT PERIOD FOR INDIVIDUALS LOSING COVERAGE BY ANOTHER ORGANIZATION.—

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3
4 “(A) IN GENERAL.—Subject to other provisions of this section, if a contract with an organization under this part is not renewed or otherwise terminated, or is renewed in a manner that discontinues coverage for individuals residing in part of the service area, each other organization with a contract under this part shall permit enrollment under this part by affected individuals enrolled with such other organization on the effective date of such termination or discontinuation of coverage.

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14 “(B) ENROLLMENT PERIOD.—The enrollment period required by subparagraph (A) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

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20 “(3) ACCEPTANCE OR DENIAL OF APPLICATION.—An eligible organization shall enroll individuals under this part in the order of application, and may deny enrollment of such an individual only if the enrollment—

1 “(A) would exceed the limits of the organi-
 2 zation’s capacity (as determined by the Sec-
 3 retary);

4 “(B) would result in an enrolled population
 5 substantially nonrepresentative, as determined
 6 in accordance with regulations of the Secretary,
 7 of the population in the geographic area served
 8 by the organization; or

9 “(C) would result in the organization’s
 10 failing to meet the requirements of sections
 11 1851E(g) and 1851F (e)(1)(B)(i) and
 12 (f)(1)(B)(i) (concerning minimum private en-
 13 rollment).

14 “(4) EFFECTIVE DATE OF ENROLLMENT.—An
 15 individual’s enrollment with an eligible organization
 16 under this part shall be effective—

17 “(A) in the case of an enrollment under
 18 paragraph (1)(A), on the first day of the third
 19 month beginning after the end of the enroll-
 20 ment period;

21 “(B) in the case of an enrollment under
 22 paragraph (1)(B), as specified by section
 23 1838(a);

1 “(C) in the case of an enrollment under
 2 paragraph (1)(C), as specified by section
 3 1838(e);

4 “(D) in the case of an enrollment under
 5 paragraph (1)(D), on the first day of the first
 6 month following the month in which the individ-
 7 ual enrolled; and

8 “(E) in the case of an enrollment under
 9 paragraph (2), 30 days after the end of the
 10 open enrollment period, or, if the Secretary de-
 11 termines that such date is not feasible, such
 12 other date as the Secretary specifies.

13 “(d) ENROLLMENT OR TERMINATION FOR HEALTH
 14 REASONS PROHIBITED.—An eligible organization—

15 “(1) shall not refuse to enroll, and shall not
 16 expel or refuse to reenroll, any individual eligible to
 17 enroll or enrolled with the organization under this
 18 part because of the individual’s health status or re-
 19 quirements for health care services;

20 “(2) shall include in any marketing materials a
 21 statement of the requirements of paragraph (1); and

22 “(3) shall notify each such individual of the re-
 23 quirements of paragraph (1) at the time of the indi-
 24 vidual’s enrollment.

1 **“SEC. 1851C. BENEFITS.**

2 “(a) BASIC BENEFITS.—

3 “(1) IN GENERAL.—An eligible organization
4 must provide to members enrolled under this part,
5 either directly or through providers and other per-
6 sons that meet the applicable requirements of this
7 title and part A of title XI—

8 “(A) those services (other than hospice
9 care) covered under parts A and B of this title,
10 for those members entitled to benefits under
11 part A and enrolled under part B, or

12 “(B) those services covered under part B,
13 for those members enrolled only under such
14 part,

15 which are available to individuals residing in the ge-
16 ographic area served by the organization.

17 “(2) PPO REQUIRED TO AFFORD ‘POINT OF
18 SERVICE’ OPTION.—An eligible organization that
19 contracts as a preferred provider organization under
20 this part, in addition to providing services in accord-
21 ance with paragraph (1), shall also pay for any serv-
22 ice (other than hospice care) furnished to a member
23 enrolled under this part (in the amounts, if any, that
24 otherwise would be paid under this title) by any en-
25 tity that may furnish that service under this title
26 (other than an entity through which the organization

1 provides services, or other than a service with re-
 2 spect to which the organization is required to pro-
 3 vide for reimbursement under subsection (e)(2) (con-
 4 cerning urgently needed services provided outside
 5 the organization).

6 “(3) PSO PROHIBITED FROM AFFORDING
 7 ‘POINT OF SERVICE’ OPTION.—An eligible organiza-
 8 tion that contracts as a provider sponsored organiza-
 9 tion under this part may not pay for any service de-
 10 scribed in paragraph (2) that is furnished to a mem-
 11 ber enrolled under this part.

12 “(b) ADDITIONAL BENEFITS OR OTHER ADJUST-
 13 MENT UNDER RISK PLANS.—

14 “(1) REQUIREMENT WHERE ADJUSTED COMMU-
 15 NITY RATES BELOW PAYMENT RATES.—Each con-
 16 tract under section 1851F(e) shall provide for ad-
 17 justment in accordance with this subsection, if—

18 “(A) the adjusted community rate for serv-
 19 ices under parts A and B (as reduced for the
 20 actuarial value of the coinsurance and
 21 deductibles under those parts) for members en-
 22 rolled under this part with the organization and
 23 entitled to benefits under part A and enrolled in
 24 part B, or

1 “(B) the adjusted community rate for serv-
 2 ices under part B (as reduced for the actuarial
 3 value of the coinsurance and deductibles under
 4 that part) for members enrolled under this part
 5 with the organization and entitled to benefits
 6 under part B only,

7 is less than the average of the per capita rates of
 8 payment to be made under section 1851F(e)(2) at
 9 the beginning of an annual contract period for mem-
 10 bers enrolled under this part with the organization
 11 and entitled to benefits under part A and enrolled
 12 in part B, or enrolled in part B only, respectively.

13 “(2) SELECTION BY ORGANIZATION OF ADDI-
 14 TIONAL BENEFITS.—An eligible organization to
 15 which paragraph (1) applies shall either—

16 “(A) provide to members described in
 17 paragraph (1) (A) or (B), as applicable, the ad-
 18 ditional benefits described in paragraph (3)
 19 which are selected by the eligible organization
 20 and which the Secretary finds are at least equal
 21 in value to the difference between that average
 22 per capita payment and the adjusted commu-
 23 nity rate (as so reduced); or

24 “(B) elect an alternative, in accordance
 25 with paragraph (4).

1 “(3) ADDITIONAL BENEFITS.—The additional
2 benefits referred to in paragraph (2) are—

3 “(A) the reduction of the premium rate or
4 other charges made with respect to services fur-
5 nished by the organization to members enrolled
6 under this part; or

7 “(B) the provision of additional health
8 benefits; or both.

9 “(4) ALTERNATIVES TO ADDITIONAL BENE-
10 FITS.—An eligible organization to which paragraph
11 (1) applies—

12 “(A) may elect to receive a lesser payment
13 such that there is no longer a difference be-
14 tween the average of the per capita rates of
15 payment to be made under section 1851F(e)(2)
16 and the adjusted community rate (as so re-
17 duced); and

18 “(B) may (with the approval of the Sec-
19 retary) provide that a part of the value of such
20 additional benefits be withheld and reserved by
21 the Secretary as provided in paragraph (5).

22 “(5) BENEFIT STABILIZATION FUND.—An orga-
23 nization having a contract under section 1851(e)
24 may (with the approval of the Secretary) provide
25 that a part of the value of additional benefits other-

1 wise required to be provided by reason of paragraph
 2 (1) be withheld and reserved in the Federal Hospital
 3 Insurance Trust Fund and in the Federal Supple-
 4 mentary Medical Insurance Trust Fund (in such
 5 proportions as the Secretary determines to be appro-
 6 priate) by the Secretary for subsequent annual con-
 7 tract periods, to the extent required to stabilize and
 8 prevent undue fluctuations in the additional benefits
 9 offered in those subsequent periods by the organiza-
 10 tion in accordance with paragraph (3). Any of such
 11 value of additional benefits which is not provided to
 12 members of the organization in accordance with
 13 paragraph (3) prior to the end of such period, shall
 14 revert for the use of such trust funds.

15 “(6) DETERMINATION OF PER CAPITA RATES.—

16 If the Secretary finds that there is insufficient en-
 17 rollment experience to determine an average of the
 18 per capita rates of payment to be made under sec-
 19 tion 1851F(e)(2) at the beginning of a contract pe-
 20 riod, the Secretary may determine such an average
 21 based on the enrollment experience of other con-
 22 tracts entered into under this part.

23 “(c) SUPPLEMENTAL BENEFITS.—

24 “(1) SUBJECT TO SECRETARY’S APPROVAL.—

25 An eligible organization may provide to individuals

1 enrolled under this part (without affording such in-
2 dividuals an option to decline such coverage), such
3 additional health care services as the Secretary may
4 approve. The Secretary shall approve any such addi-
5 tional services unless the Secretary determines that
6 including such additional services will substantially
7 discourage enrollment by covered individuals with
8 the organization.

9 “(2) AT ENROLLEES’ OPTION.—Such an orga-
10 nization may provide to such individuals such addi-
11 tional health care services as such individuals may
12 elect, at their option, to have covered.

13 “(3) DISCLOSURE OF PREMIUM.—Such an or-
14 ganization shall furnish to such individuals informa-
15 tion on the portion of its premium rate or other
16 charges applicable to such supplemental benefits.

17 “(d) STANDARDIZED PACKAGES OF ADDITIONAL
18 BENEFITS.—Any health care service described in sub-
19 section (b) or (c) that is included in a standardized pack-
20 age of benefits specified by the Secretary may be offered
21 only as part of that standardized package.

22 “(e) AVAILABILITY AND ACCESSIBILITY OF SERV-
23 ICES.—

24 “(1) SERVICES PROVIDED THROUGH THE ORGA-
25 NIZATION.—An eligible organization with a contract

1 under this part must make the services it has con-
2 tracted to provide to individuals enrolled with the or-
3 ganization under this part—

4 “(A) available and accessible to each such
5 individual, within the area served by the organi-
6 zation, with reasonable promptness and in a
7 manner which assures continuity, and

8 “(B) when medically necessary, available
9 and accessible 24 hours a day and 7 days a
10 week.

11 “(2) SERVICES PROVIDED OUTSIDE THE ORGA-
12 NIZATION.—An eligible organization with a contract
13 under this part must provide for reimbursement with
14 respect to services described in paragraph (1) pro-
15 vided to such an individual other than through the
16 organization, if—

17 “(A) the services were medically necessary
18 and immediately required because of an unfore-
19 seen illness, injury, or condition; and

20 “(B) it was not reasonable given the cir-
21 cumstances to obtain the services through the
22 organization.

1 **“SEC. 1851D. LIABILITY OF BENEFICIARY AND THIRD PAR-**
 2 **TIES.**

3 “(a) LIMITS ON LIABILITY FOR REQUIRED BENE-
 4 FITS.—

5 “(1) LIMITATION TO ACTUARIAL VALUE OF
 6 FEE-FOR-SERVICE COVERAGE.—Total charges by an
 7 eligible organization to individuals enrolled with the
 8 organization under this part, with respect to services
 9 described in section 1851C(a)—

10 “(A) shall include no amounts other than
 11 the individual’s share of premiums, deductibles,
 12 coinsurance, and copayments; and

13 “(B) shall not exceed the actuarial value of
 14 the deductibles and coinsurance that would be
 15 applicable under this title on the average to
 16 such individuals if they were not members of an
 17 eligible organization.

18 “(2) ALTERNATIVE DATA.—If the Secretary
 19 finds that adequate data are not available for the de-
 20 termination required under paragraph (1) with re-
 21 spect to an eligible organization, the Secretary may
 22 substitute the actuarial value of the deductibles and
 23 coinsurance applicable on the average to individuals
 24 in the area, in the State, or in the United States,
 25 eligible to enroll under this part with the organiza-
 26 tion, or other appropriate data.

1 “(b) LIMITS ON PREMIUM FOR SUPPLEMENTAL BEN-
 2 EFITS.—If an eligible organization provides to its mem-
 3 bers enrolled under this part supplemental benefits in ac-
 4 cordance with section 1851C, the sum of—

5 “(1) the portion of such organization’s premium
 6 rate charged, with respect to such supplemental ben-
 7 efits, to members enrolled under this part, and

8 “(2) the deductibles, coinsurance, and copay-
 9 ments charged, with respect to such services to such
 10 members,

11 shall not exceed the adjusted community rate for such
 12 services.

13 “(c) LIMITATION ON AMOUNTS AN OUT-OF-PLAN
 14 PHYSICIAN OR OTHER ENTITY MAY COLLECT.—

15 “(1) IN GENERAL.—A physician or other entity
 16 (other than a provider of services) that does not
 17 have a contract establishing payment amounts for
 18 services furnished to an individual enrolled under
 19 this part with an eligible organization shall accept as
 20 payment in full for services that are furnished to
 21 such an individual the amounts that the physician or
 22 other entity could collect if the individual were not
 23 so enrolled. Any penalty or other provision of law
 24 that applies to such payments with respect to an in-
 25 dividual entitled to benefits under this title (but not

1 enrolled with an eligible organization under this
 2 part) shall also apply with respect to an individual
 3 so enrolled.

4 “(2) SIMILAR REQUIREMENTS.—For similar re-
 5 quirements applicable to providers of services, see
 6 section 1866(a)(1)(O).

7 “(d) PLAN AS A SECONDARY PAYER.—Notwithstand-
 8 ing any other provision of law, an eligible organization
 9 may (in the case of the provision of services for which the
 10 Medicare program is a secondary payer under section
 11 1862(b)(2)) charge or authorize the provider of such serv-
 12 ices to charge, in accordance with the charges allowed
 13 under such law, plan, or policy—

14 “(1) the insurance carrier, employer, or other
 15 entity which under such law, plan, or policy is to pay
 16 for the provision of such services, or

17 “(2) such member to the extent that the mem-
 18 ber has been paid under such law, plan, or policy for
 19 such services.

20 **“SEC. 1851E. BENEFICIARY PROTECTIONS.**

21 “(a) EXPLANATION OF RIGHTS AND RESTRIC-
 22 TIONS.—Each eligible organization shall provide each en-
 23 rollee, at the time of enrollment and not less frequently
 24 than annually thereafter, an explanation of the enrollee’s

1 rights under this part and other important information,
2 including the following:

3 “(1) COVERAGE.—The enrollee’s rights to bene-
4 fits from the organization, and benefit limitations,
5 including—

6 “(A) out-of-area coverage provided by the
7 organization,

8 “(B) the organization’s coverage of emer-
9 gency services and urgently needed care, and

10 “(C) the restrictions on payments under
11 this title for services furnished other than by or
12 through the organization.

13 “(2) TERMINATION OF COVERAGE.—An expla-
14 nation that—

15 “(A) the organization may terminate or
16 refuse to renew the contract under this part;
17 and

18 “(B) termination of such contract could re-
19 sult in termination of enrollment of individuals
20 with the organization.

21 “(3) PATIENT RIGHTS.—Safeguards on enroll-
22 ees’ rights, including—

23 “(A) appeal rights of enrollees,

24 “(B) the right to be informed about var-
25 ious treatment options, and

1 “(C) the right to decline treatment.

2 “(4) EMERGENCIES.—The appropriate use of
3 the 911 emergency telephone system in the case of
4 medical emergencies.

5 “(5) FRAUD AND ABUSE REPORTING.—The
6 processes for reporting potential fraud or abuse.

7 “(b) NOTIFICATION OF TERMINATION OPTION IN
8 MARKETING MATERIALS.—Each eligible organization
9 with a contract under this part shall include the informa-
10 tion required by subsection (a)(2) in any marketing mate-
11 rials described in section 1851B(b)(3) that are distributed
12 by an eligible organization to individuals eligible to enroll
13 under this part with the organization.

14 “(c) GRIEVANCE MECHANISM.—An eligible organiza-
15 tion with a contract under this part must provide mean-
16 ingful procedures for hearing and resolving grievances be-
17 tween the organization (including any entity or individual
18 through which the organization provides health care serv-
19 ices) and members enrolled with the organization under
20 this part.

21 “(d) COVERAGE DETERMINATIONS AND APPEALS.—

22 “(1) DETERMINATION BY ORGANIZATION.—An
23 eligible organization with a contract under this part
24 shall have a procedure for determining whether an
25 individual enrolled with the organization under this

1 part is entitled to receive a health service described
2 in section 1851C(a) and the amount (if any) that
3 the individual is required to pay for that service,
4 which includes the following elements:

5 “(A) TIMELY REVIEW.—The organization
6 shall provide for review of a coverage issue
7 within 30 days of a request by such individual,
8 and for reconsideration, where requested, within
9 60 days after the initial review.

10 “(B) EXPEDITED REVIEW IN URGENT
11 CASES.—The organization shall have an expe-
12 dited process for review and reconsideration of
13 a coverage issue in cases in which delayed treat-
14 ment may place the health of such individual in
15 jeopardy, risk serious impairment of bodily
16 functions, or limit medically appropriate treat-
17 ment options.

18 “(2) REVIEW BY EXTERNAL CONTRACTOR.—An
19 individual dissatisfied with a determination under
20 paragraph (1) concerning such individual’s coverage
21 under a contract under this part is entitled to a
22 hearing before an independent reviewer designated
23 by the Secretary.

24 “(3) APPEAL TO SECRETARY.—An individual
25 dissatisfied with a determination under paragraph

1 (2) concerning such individual's coverage under a
 2 contract under this part is entitled, if the amount in
 3 controversy is \$100 or more, to a hearing before the
 4 Secretary to the same extent as is provided in sec-
 5 tion 205(b), and in any such hearing the Secretary
 6 shall make the eligible organization a party. If the
 7 amount in controversy is \$1,000 or more, the indi-
 8 vidual or eligible organization shall, upon notifying
 9 the other party, be entitled to judicial review of the
 10 Secretary's final decision as provided in section
 11 205(g), and both the individual and the eligible or-
 12 ganization shall be entitled to be parties to that judi-
 13 cial review. In applying sections 205(b) and 105(g)
 14 as provided in this subparagraph, and in applying
 15 section 205(l) thereto, any reference therein to the
 16 Commissioner of Social Security or the Social Secu-
 17 rity Administration shall be considered a reference
 18 to the Secretary or the Department of Health and
 19 Human Services, respectively.

20 “(e) QUALITY ASSURANCE.—

21 “(1) INTERNAL QUALITY ASSURANCE (IQA) PRO-
 22 GRAM.—

23 “(A) IN GENERAL.—Subject to subpara-
 24 graph (B), an eligible organization must have
 25 arrangements, established in accordance with

1 regulations of the Secretary, for an ongoing
 2 quality assurance program for health care serv-
 3 ices provided to individuals enrolled with the or-
 4 ganization under this part that—

5 “(i) focuses on health outcomes; and

6 “(ii) provides for review by physicians
 7 and other health care professionals of the
 8 process followed in the provision of such
 9 health care services.

10 “(B) ACCEPTANCE OF ACCREDITATION IN
 11 SATISFACTION OF IQA STANDARDS.—If (or to
 12 the extent that) an eligible organization has
 13 been accredited by an accrediting body whose
 14 standards with respect to one or more of the
 15 elements of an internal quality assurance pro-
 16 gram are at least as stringent as such stand-
 17 ards pursuant to subparagraph (A), the organi-
 18 zation shall be deemed to meet the require-
 19 ments of such subparagraph (A) with respect to
 20 such program elements.

21 “(2) EXTERNAL QUALITY REVIEW.—

22 “(A) REQUIREMENTS.—Each contract with
 23 an eligible organization under this part shall
 24 provide that the organization will maintain an
 25 agreement with—

1 “(i) a utilization and quality control
 2 peer review organization (which has a con-
 3 tract with the Secretary under part B of
 4 title XI for the area in which the eligible
 5 organization is located);

6 “(ii) an entity selected by the Sec-
 7 retary under section 1154(a)(4)(C); or

8 “(iii) an independent quality review
 9 and improvement organization selected by
 10 the organization and approved by the Sec-
 11 retary,

12 under which the review organization will per-
 13 form functions under section 1154(a) (4)(B)
 14 and (14) (other than those performed under
 15 contracts described in section 1866(a)(1)(F))
 16 with respect to services, furnished by the eligi-
 17 ble organization, for which payment may be
 18 made under this title.

19 “(B) QUALITY REVIEW AS COVERED SERV-
 20 ICE.—For purposes of payment under this title,
 21 the cost of such agreement to the eligible orga-
 22 nization shall be considered a cost incurred by
 23 a provider of services in providing covered serv-
 24 ices under this title and shall be paid directly
 25 by the Secretary to the review organization on

1 behalf of such eligible organization in accord-
 2 ance with a schedule established by the Sec-
 3 retary.

4 “(C) PAYMENT FROM TRUST FUNDS.—

5 Such payments—

6 “(i) shall be transferred in appro-
 7 priate proportions from the Federal Hos-
 8 pital Insurance Trust Fund and from the
 9 Supplementary Medical Insurance Trust
 10 Fund, without regard to amounts appro-
 11 priated in advance in appropriation Acts,
 12 in the same manner as transfers are made
 13 for payment for services provided directly
 14 to beneficiaries, and

15 “(ii) shall not be less in the aggregate
 16 for such organizations for a fiscal year
 17 than the amounts the Secretary determines
 18 to be sufficient to cover the costs of such
 19 organizations’ conducting activities de-
 20 scribed in subparagraph (A) with respect
 21 to such eligible organizations under part B
 22 of title XI.

23 “(f) BENEFICIARY ADVANCE DIRECTIVES CONCERN-

24 ING MEDICAL TREATMENT.—A contract under this part

25 shall provide that an eligible organization shall meet the

1 requirements of section 1866(f) (relating to maintaining
 2 written policies and procedures respecting advance direc-
 3 tives).

4 “(g) PRIVATE ENROLLMENT REQUIREMENTS.—

5 “(1) 50 PERCENT REQUIREMENT.—Subject to
 6 section 11205 of the Emergency Medicare Protec-
 7 tion Act of 1996, each eligible organization with
 8 which the Secretary enters into a contract under this
 9 part shall have, for the duration of such contract, an
 10 enrolled membership (without consideration of mem-
 11 bers enrolled in the program under title XIX) at
 12 least one-half of which consists of individuals who
 13 are entitled to benefits under this title.

14 “(2) EXCEPTIONS.—The Secretary may modify
 15 or waive the requirement imposed by paragraph (1)
 16 only in the following circumstances:

17 “(A) AREA WITH LARGE MEDICARE POPU-
 18 LATION.—If more than 50 percent of the popu-
 19 lation of the area served by the organization
 20 consists of individuals who are entitled to bene-
 21 fits under this title.

22 “(B) INITIAL PERIOD FOR GOVERNMENTAL
 23 CONTRACTOR.—In the case of an eligible orga-
 24 nization that is owned and operated by a gov-
 25 ernmental entity, only with respect to a period

1 of three years beginning on the date the organi-
2 zation first enters into a contract under this
3 part, and only if the organization has taken and
4 is making reasonable efforts to enroll individ-
5 uals who are not entitled to benefits under this
6 title.

7 “(C) UNDERSERVED RURAL AREA.—If the
8 organization serves an underserved rural area.

9 “(D) CONTRACTOR WITH GOOD PAST
10 RECORD.—If the organization has had contracts
11 under this part for a total of at least three
12 years, has complied with all applicable require-
13 ments during that period, maintains a level of
14 enrollment of individuals not entitled to benefits
15 under this title determined by the Secretary,
16 and complies with any additional monitoring re-
17 quirements established by the Secretary.

18 “(E) CONTRACTOR WITH GOOD RECORD IN
19 ANOTHER GEOGRAPHIC AREA.—If—

20 “(i) the Secretary has not previously
21 entered into a contract with the organiza-
22 tion under this part in the same geo-
23 graphic area (or has entered into contracts
24 for a total of three years or less),

1 “(ii) the organization (or a parent
2 company that controls the organization)
3 has entered into (or subsidiaries of the or-
4 ganization or parent company have entered
5 into) contracts under this part for at least
6 three different geographic areas—

7 “(I) for which no waiver has been
8 granted under this paragraph and
9 during the course of which there has
10 been compliance with all applicable re-
11 quirements; or

12 “(II) for which a waiver has been
13 granted under subparagraph (D);

14 “(iii) the organization (or parent com-
15 pany) demonstrates to the Secretary a
16 long-term business and financial commit-
17 ment to the geographic area served by the
18 organization, and the Secretary determines
19 that a waiver is necessary to promote com-
20 petition in that area; and

21 “(iv) the organization complies with
22 all applicable requirements and any addi-
23 tional monitoring requirements established
24 by the Secretary.

1 “(F) OTHER SITUATIONS.—In such situa-
 2 tions and under such conditions as the Sec-
 3 retary determines will be in the best interest of
 4 individuals entitled to benefits under this title.

5 “(h) ACCESS TO SPECIALTY CARE AND CASE MAN-
 6 AGEMENT.—Each eligible organization shall ensure that
 7 enrollees with chronic illnesses or disabilities and other en-
 8 rollees as appropriate, shall have access to medically ap-
 9 propriate specialty care and medically appropriate case
 10 management.

11 “(i) RESTRICTIONS ON PHYSICIAN INCENTIVE
 12 PLANS.—

13 “(1) CRITERIA.—Each contract with an eligible
 14 organization under this part shall provide that the
 15 organization may not operate any physician incentive
 16 plan (as defined in paragraph (2)) unless the follow-
 17 ing requirements are met:

18 “(A) NO INDUCEMENT TO LIMIT CARE.—
 19 No specific payment is made directly or indi-
 20 rectly under the plan to a physician or physi-
 21 cian group as an inducement to reduce or limit
 22 medically necessary services provided with re-
 23 spect to a specific individual enrolled with the
 24 organization.

1 “(B) REQUIREMENTS WHERE PHYSICIAN
2 AT FINANCIAL RISK.—If the plan places a phy-
3 sician or physician group at substantial finan-
4 cial risk (as determined by the Secretary) for
5 services not provided by the physician or physi-
6 cian group, the organization—

7 “(i) provides stop-loss protection for
8 the physician or group that is adequate
9 and appropriate, based on standards devel-
10 oped by the Secretary that take into ac-
11 count the number of physicians placed at
12 such substantial financial risk in the group
13 or under the plan and the number of indi-
14 viduals enrolled with the organization who
15 receive services from the physician or the
16 physician group, and

17 “(ii) conducts periodic surveys of both
18 individuals enrolled and individuals pre-
19 viously enrolled with the organization to
20 determine the degree of access of such in-
21 dividuals to services provided by the orga-
22 nization and satisfaction with the quality
23 of such services.

24 “(C) DISCLOSURE TO SECRETARY.—The
25 organization provides the Secretary with de-

1 scriptive information regarding the plan, suffi-
 2 cient to permit the Secretary to determine
 3 whether the plan is in compliance with the re-
 4 quirements of this paragraph.

5 “(2) DEFINITION OF ‘PHYSICIAN INCENTIVE
 6 PLAN’.—In this subsection, the term ‘physician in-
 7 centive plan’ means any compensation arrangement
 8 between an eligible organization and a physician or
 9 physician group that may directly or indirectly have
 10 the effect of reducing or limiting services provided
 11 with respect to individuals enrolled with the organi-
 12 zation.

13 “(j) ADDITIONAL STANDARDS FOR OTHER MANAGED
 14 CARE ORGANIZATIONS.—The Secretary shall establish
 15 such additional standards for entities treated as eligible
 16 organizations under section 1851A(a)(5) as the Secretary
 17 determines appropriate.

18 **“SEC. 1851F. CONTRACTS WITH, AND PAYMENTS TO, PLANS.**

19 “(a) GENERAL RULES ON PAYMENTS TO CONTRACT-
 20 ING ORGANIZATION.—

21 “(1) PAYMENT TO ORGANIZATION ONLY UNDER
 22 CONTRACT.—Payments to an eligible organization
 23 under a risk or partial risk contract under this part
 24 shall be in lieu of the amounts which (in the absence
 25 of the contract) would be otherwise payable, pursu-

ant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this part, except as otherwise provided in this subsection.

“(2) PAYMENT FOR ENROLLED INDIVIDUAL ONLY TO ORGANIZATION WITH CONTRACT.—If an individual is enrolled under this part with an eligible organization, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services (other than hospice care) furnished to the individual, except as otherwise provided in this subsection.

“(3) EXCEPTIONS.—

“(A) FAILURE OF ORGANIZATION TO MAKE PROMPT PAYMENT.—For the exception to paragraph (1) that applies if an eligible organization fails to make prompt payments under the contract, see subsection (d).

“(B) MID-YEAR NATIONAL COVERAGE DETERMINATION.—For the exception to paragraph (1) that applies if the Secretary makes a mid-contract year determination that expands benefits under this title, see subsection (i).

“(C) PATIENT HOSPITALIZED ON DATE OF ENROLLMENT.—For the exception to para-

graphs (1) and (2) that applies in the case of a patient hospitalized on the effective date of enrollment with an organization under this part, see subsection (h).

“(D) MEDICAL EDUCATION AND DIS-
PROPORTIONATE SHARE HOSPITAL PAY-
MENTS.—The Secretary may make payments (as otherwise provided under this title) to hospitals for payment adjustments for hospitals serving a disproportionate share of low-income patients, for the indirect costs of medical education, or for direct graduate medical education.

“(E) ENROLLED INDIVIDUAL WHO ELECTS HOSPICE CARE.—For the exception to paragraphs (1) and (2) that applies in the case of an individual who is enrolled under this part with an eligible organization and elects under section 1812(d)(1) to receive hospice care provided by a particular hospice program, see subsection (l).

“(4) PAYMENT FROM TRUST FUNDS.—The payment to an eligible organization under this part of individuals enrolled under this part with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal

1 Hospital Insurance Trust Fund and the Federal
2 Supplementary Medical Insurance Trust Fund. The
3 portion of that payment to the organization for a
4 month to be paid by each trust fund shall be deter-
5 mined each year by the Secretary based on the rel-
6 ative weight that benefits from each fund contribute
7 to the per capita payments made under section
8 1851F(e)(2).

9 “(b) CONTRACT TERM; RENEWAL; TERMINATION.—

10 “(1) IN GENERAL.—Each contract under this
11 part shall be for a term of at least one year, as de-
12 termined by the Secretary, beginning on a date spec-
13 ified in the contract, and may be made automatically
14 renewable from term to term in the absence of no-
15 tice by either party of intention to terminate at the
16 end of the current term, except as provided in para-
17 graph (2).

18 “(2) TERMINATION BY SECRETARY FOR
19 CAUSE.—The Secretary may terminate any contract
20 described in paragraph (1) at any time (after such
21 reasonable notice and opportunity for hearing to the
22 eligible organization involved as may be provided in
23 regulations), if the Secretary finds that the organi-
24 zation—

1 “(A) has failed substantially to carry out
2 the contract,

3 “(B) is carrying out the contract in a man-
4 ner inconsistent with the efficient and effective
5 administration of this part, or

6 “(C) no longer substantially meets the ap-
7 plicable conditions of this part.

8 “(c) CONTRACT TERMS AND CONDITIONS.—Each
9 contract under this part shall provide for the following:

10 “(1) AUDIT, INSPECTIONS, EVALUATIONS.—The
11 contract shall provide that the Secretary, or any per-
12 son or organization designated by the Secretary—

13 “(A) shall have the right to inspect or oth-
14 erwise evaluate—

15 “(i) the quality, appropriateness, and
16 timeliness of services performed under the
17 contract; and

18 “(ii) the facilities of the organization
19 when there is reasonable evidence of some
20 need for such inspection; and

21 “(B) shall have the right to audit and in-
22 spect any books and records of the eligible or-
23 ganization that pertain—

1 “(i) to the ability of the organization
 2 to bear the risk of potential financial
 3 losses; or

4 “(ii) to services performed or deter-
 5 minations of amounts payable under the
 6 contract.

7 “(2) NOTICE TO ENROLLEES IN EVENT OF TER-
 8 MINATION OF CONTRACT.—The contract shall re-
 9 quire the organization to provide (and pay for) writ-
 10 ten notice in advance of the contract’s termination,
 11 as well as a description of alternatives for obtaining
 12 benefits under this title, to each individual enrolled
 13 under this part with the organization.

14 “(3) DISCLOSURES.—

15 “(A) FINANCIAL AND LIABILITY INFORMA-
 16 TION.—The contract shall require the organiza-
 17 tion to comply with subsections (a) and (c) of
 18 section 1318 of the Public Health Service Act
 19 (relating to disclosure of certain financial infor-
 20 mation) and with the requirement of section
 21 1301(c)(7) of such Act (relating to liability ar-
 22 rangements to protect members).

23 “(B) OWNERSHIP AND CONTROL INTER-
 24 ESTS.—The contract shall require the organiza-
 25 tion to report the information required to be re-

1 ported by disclosing entities under section 1124
2 (concerning ownership and control interests).

3 “(C) LOANS AND OTHER FINANCIAL AR-
4 RANGEMENTS.—The contract shall require the
5 organization to notify the Secretary of loans
6 and other special financial arrangements which
7 are made between the organization and sub-
8 contractors, affiliates, and related parties.

9 “(4) OTHER TERMS AND CONDITIONS.—The
10 contract shall contain such other terms and condi-
11 tions not inconsistent with this part (including re-
12 quirements that the organization furnish to the Sec-
13 retary such information) as the Secretary may find
14 necessary and appropriate.

15 “(d) PROMPT PAYMENT BY ELIGIBLE ORGANIZA-
16 TION.—

17 “(1) REQUIREMENT.—A contract under this
18 part shall require an eligible organization to provide
19 prompt payment (consistent with the provisions of
20 sections 1816(c)(2) and 1842(c)(2)) of claims sub-
21 mitted for services and supplies furnished to individ-
22 uals pursuant to such contract, if the services or
23 supplies are not furnished under a contract between
24 the organization and the provider or supplier.

1 “(2) SECRETARY’S OPTION TO BYPASS NON-
 2 COMPLYING ORGANIZATION.—In the case of an eligi-
 3 ble organization which the Secretary determines,
 4 after notice and opportunity for a hearing, has failed
 5 to make payments of amounts in compliance with
 6 paragraph (1), the Secretary may provide for direct
 7 payment of the amounts owed to providers and sup-
 8 pliers for such covered services furnished to individ-
 9 uals enrolled under this part under the contract. If
 10 the Secretary provides for such direct payments, the
 11 Secretary shall provide for an appropriate reduction
 12 in the amount of payments otherwise made to the
 13 organization under this part to reflect the amount of
 14 the Secretary’s payments (and costs incurred by the
 15 Secretary in making such payments).

16 “(e) RISK CONTRACTS.—

17 “(1) IN GENERAL.—

18 “(A) SECRETARY’S AUTHORITY TO CON-
 19 TRACT.—The Secretary may enter into a risk
 20 contract under this subsection (under which
 21 payment by the Secretary for covered services
 22 to individuals eligible for benefits under this
 23 title is based on the per capita rate determined
 24 annually under paragraph (2)) with any eligible

organization meeting the requirements of subparagraph (B).

“(B) REQUIREMENTS APPLICABLE TO CONTRACTING ORGANIZATIONS.—An eligible organization qualified to enter a contract under this subsection must meet the following requirements:

“(i) MINIMUM PRIVATE ENROLLMENT.—The organization must have at least 5,000 members not eligible for benefits under this title or title XIX, except that the Secretary may enter into such a contract with an eligible organization that has fewer such members—

“(I) if the organization primarily serves members residing outside of urbanized areas, or

“(II) in such situations and under such conditions as the Secretary determines will be in the best interests of individuals entitled to benefits under this title.

“(ii) ABILITY TO BEAR RISK.—The organization must satisfy the Secretary that it has the ability to bear the risk of

1 potential losses under a risk contract
2 under this subsection.

3 “(2) PAYMENTS.—

4 “(A) MONTHLY PAYMENTS.—Under a con-
5 tract under paragraph (1), the Secretary shall
6 make monthly payments in advance to each eli-
7 gible organization, with respect to each individ-
8 ual enrolled under this part with the organiza-
9 tion in a payment area for a month, in an
10 amount equal to one-twelfth of the annual capi-
11 tation rate (as calculated under paragraph (4))
12 with respect to that individual for that area, ad-
13 justed for such risk factors as age, disability
14 status, gender, institutional status, ESRD sta-
15 tus, and such other factors as the Secretary de-
16 termines to be appropriate, so as to ensure ac-
17 tuarial equivalence. The Secretary may add to,
18 or modify, or substitute for such factors, if such
19 changes will improve the determination of actu-
20 arial equivalence.

21 “(B) ADJUSTMENT TO REFLECT NUMBER
22 OF ENROLLEES.—

23 “(i) IN GENERAL.—The amount of
24 payment under this paragraph may be
25 retroactively adjusted to take into account

1 any difference between the actual number
 2 of individuals enrolled with the organiza-
 3 tion under this part and the number of
 4 such individuals estimated to be so enrolled
 5 in determining the amount of the advance
 6 payment.

7 “(ii) SPECIAL RULE FOR CERTAIN EN-
 8 ROLLEES.—

9 “(I) IN GENERAL.—Subject to
 10 subclause (II), the Secretary may
 11 make retroactive adjustments under
 12 clause (i) to take into account individ-
 13 uals enrolled during the period (not to
 14 exceed 90 days) beginning on the date
 15 on which the individual enrolls with
 16 an eligible organization under a plan
 17 operated, sponsored, or contributed to
 18 by the individual’s employer or former
 19 employer (or the employer or former
 20 employer of the individual’s spouse)
 21 and ending on the date on which the
 22 individual is enrolled in the organiza-
 23 tion under this part.

24 “(II) EXCEPTION.—No adjust-
 25 ment may be made under subclause

1 (I) with respect to any individual who
 2 does not certify that the organization
 3 provided the individual with the dis-
 4 closure statement described in section
 5 1851E(a) at the time the individual
 6 enrolled with the organization.

7 “(3) ANNUAL ANNOUNCEMENT OF PAYMENT
 8 RATES.—

9 “(A) ANNUAL ANNOUNCEMENT.—The Sec-
 10 retary shall annually determine, and shall an-
 11 nounce (in a manner intended to provide notice
 12 to interested parties) not later than August 1
 13 before the calendar year concerned—

14 “(i) the annual capitation rate for
 15 each payment area for the year;

16 “(ii) the risk and other factors to be
 17 used in adjusting the rates under para-
 18 graph (2)(A) for payments for months in
 19 that year;

20 “(iii) any adjustments to be made to
 21 offset favorable selection under paragraph
 22 (4)(F);

23 “(iv) any adjustments for national
 24 coverage determinations under paragraph
 25 (4)(G); and

1 “(v) any adjustment made to the
2 blended payment rate under paragraph
3 (4)(E).

4 “(B) ADVANCE NOTICE OF METHODOLOGI-
5 CAL CHANGES.—At least 45 days before making
6 the announcement under subparagraph (A) for
7 a year, the Secretary shall provide for notice to
8 eligible organizations of proposed changes to be
9 made in the methodology from the methodology
10 and assumptions used in the previous an-
11 nouncement and shall provide eligible organiza-
12 tions an opportunity to comment on the pro-
13 posed changes.

14 “(C) EXPLANATION OF ASSUMPTIONS.—In
15 each announcement made under subparagraph
16 (A) for a year, the Secretary shall include an
17 explanation of the assumptions and changes in
18 methodology used in the announcement in suffi-
19 cient detail so that eligible organizations can
20 compute monthly adjusted capitation rates for
21 individuals in each payment area.

22 “(4) CALCULATION OF ANNUAL CAPITATION
23 RATES.—

24 “(A) IN GENERAL.—The annual capitation
25 rate for a payment area for a calendar year is

equal to the greatest of the following (adjusted as provided by subparagraphs (F) through (H)):

“(i) BLENDED CAPITATION RATE.—

The sum of—

“(I) the area-specific percentage (as specified under subparagraph (B) for the year) of the area-specific capitation rate for the year for the payment area, as determined under subparagraph (C), and

“(II) the national percentage (as specified under subparagraph (B) for the year) of the input-price-adjusted national capitation rate for the year, as determined under subparagraph (D),

multiplied by a budget neutrality factor adjustment factor determined under subparagraph (E).

“(ii) MINIMUM AMOUNT.—

“(I) for 1997, \$325; and

“(II) for a subsequent year, the amount determined under this clause for the preceding year increased by

1 the national average per capital
 2 growth percentage, as specified under
 3 subparagraph (I) for that succeeding
 4 year.

5 “(iii) MINIMUM INCREASE OVER PRE-
 6 VIOUS YEAR’S RATE.—

7 “(I) for 1997, 102 percent of the
 8 annual per capita rate of payment for
 9 1996 determined under section
 10 1876(a)(1)(C) for the payment area;
 11 and

12 “(II) for a subsequent year, 102
 13 percent of the annual capitation rate
 14 under this paragraph for the preced-
 15 ing year for the payment area.

16 “(B) AREA-SPECIFIC AND NATIONAL PER-
 17 CENTAGES.—For purposes of subparagraph
 18 (A)(i)—

19 “(i) for 1997, the ‘area-specific per-
 20 centage’ is 90 percent and the ‘national
 21 percentage’ is 10 percent,

22 “(ii) for 1998, the ‘area-specific per-
 23 centage’ is 85 percent and the ‘national
 24 percentage’ is 15 percent,

1 “(iii) for 1999, the ‘area-specific per-
 2 centage’ is 80 percent and the ‘national
 3 percentage’ is 20 percent,

4 “(iv) for 2000, the ‘area-specific per-
 5 centage’ is 75 percent and the ‘national
 6 percentage’ is 25 percent, and

7 “(v) for a year after 2000, the ‘area-
 8 specific percentage’ is 70 percent and the
 9 ‘national percentage’ is 30 percent.

10 “(C) AREA-SPECIFIC CAPITATION RATE.—

11 “(i) IN GENERAL.—For purposes of
 12 subparagraph (A)(i)(I), subject to clause
 13 (ii) of this subparagraph, the area-specific
 14 capitation rate for a payment area—

15 “(I) for 1997 is the annual per
 16 capita rate of payment for 1996 de-
 17 termined under section 1876(a)(1)(C)
 18 for the payment area, increased by
 19 the national average per capita growth
 20 percentage for 1997 (as specified in
 21 subparagraph (I)), and

22 “(II) for a subsequent year is the
 23 area-specific capitation rate for the
 24 previous year for the payment area,

increased by that percentage for that subsequent year.

“(ii) REMOVAL OF MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—In determining the area-specific capitation rate under clause (i)(II) for 1998 and for subsequent years, the area-specific capitation rate for 1997 determined under clause (i)(I) shall be adjusted to exclude from that rate any amount which the Secretary estimates was payable under this title during 1996 for payment adjustments under section 1886(d)(5)(F) for hospitals serving a disproportionate share of low-income patients, for the indirect costs of medical education under section 1886(d)(5)(B), or for direct graduate medical education costs under section 1886(h).

“(D) INPUT-PRICE-ADJUSTED NATIONAL CAPITATION RATE.—

“(i) IN GENERAL.—For purposes of subparagraph (A)(i)(II), the ‘input-price-

adjusted national capitation rate' for a year for a payment area is equal to the sum, for all the types of services under this title (as classified by the Secretary), of the product (for each such type) of—

“(I) the national standardized capitation rate (determined under clause (ii)) for the year,

“(II) the proportion of that rate for the year that is attributable to that type of services, and

“(III) an index that reflects (for that year and that type of services) the relative input price of the services in the area compared with the national input price of the services.

In applying subclause (III), the Secretary shall, subject to clause (iii), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

“(ii) NATIONAL STANDARDIZED CAPITATION RATE.—In clause (i)(I), the ‘national standardized capitation rate’ for a year is equal to—

1 “(I) the sum (for all payment
 2 areas) of the product of the area-spe-
 3 cific capitation rate for the year for
 4 the area under subparagraph (C) and
 5 the average number of individuals en-
 6 titled to benefits under this title who
 7 reside in that area in the year, divided
 8 by

9 “(II) the total average number of
 10 individuals entitled to benefits under
 11 this title who reside in all payment
 12 areas in the year.

13 “(iii) SPECIAL RULES FOR 1997 AND
 14 1998.—In applying this subparagraph for
 15 1997—

16 “(I) services under this title shall
 17 be divided into services under part A
 18 and services under part B,

19 “(II) the proportions described in
 20 clause (i)(II) for such types of services
 21 shall be, for services under part A, the
 22 ratio (expressed as a percentage) of
 23 the average annual per capita rate of
 24 payment for the area for part A for
 25 1995 to the total average annual per

1 capita rate of payment for the area
2 for parts A and B, and, for services
3 under part B, 100 percent minus the
4 percentage described for services
5 under part A,

6 “(III) for services under part A,
7 70 percent of payments attributable
8 to those services shall be adjusted by
9 the index used under section
10 1886(d)(3)(E) to adjust payment
11 rates for relative hospital wage levels
12 for hospitals located in the payment
13 area involved,

14 “(IV) for services under part B,
15 66 percent of payment attributable to
16 those services shall be adjusted by the
17 index of the geographic area factors
18 used under section 1848(e) to adjust
19 payment rates for physicians’ services
20 furnished in the payment area, and 70
21 percent of the remaining 34 percent
22 shall be adjusted by the index de-
23 scribed in subclause (III), and

24 “(V) the index values shall be
25 computed based only on the popu-

1 lation of individuals entitled to bene-
2 fits under this title who are 65 years
3 of age or older and who have not been
4 determined to have end-stage renal
5 disease.

6 The Secretary may continue to apply the
7 rules described in the preceding subclauses
8 (or similar rules) in 1998.

9 “(E) BUDGET NEUTRALITY ADJUSTMENT
10 FACTOR.—For each year, the Secretary shall
11 determine a budget neutrality adjustment factor
12 so that the aggregate of the payments under
13 this part shall not exceed the aggregate pay-
14 ments that would have been made under this
15 part if the area-specific percentage for the year
16 had been 100 percent and the national percent-
17 age had been 0 percent.

18 “(F) ADJUSTMENT TO OFFSET COST OF
19 FAVORABLE SELECTION.—For each year, the
20 Secretary shall determine the adjustment, if
21 any, needed to offset any estimated increases in
22 total projected expenditures under this title re-
23 sulting from increases in enrollment in eligible
24 organizations attributable to enactment of this
25 part.

1 “(G) ADJUSTMENT FOR NATIONAL COV-
2 ERAGE DETERMINATIONS.—If the Secretary
3 makes a determination with respect to coverage
4 under this title that the Secretary projects will
5 result in a significant increase in the costs to
6 eligible organizations of providing benefits
7 under contracts under this part (for periods
8 after any period described in subsection (i)), the
9 Secretary shall make an appropriate adjustment
10 in the payments to eligible organizations under
11 this part.

12 “(H) ADJUSTMENT TO REMOVE MEDICAL
13 EDUCATION AND DISPROPORTIONATE SHARE
14 HOSPITAL PAYMENTS FROM 1997 RATES.—An-
15 nual capitation rates for 1997 shall be adjusted
16 to exclude from that rate any amount which the
17 Secretary estimates were payable under this
18 title during 1996 for payment adjustments
19 under section 1886(d)(5)(F) for hospitals serv-
20 ing a disproportionate share of low-income pa-
21 tients, for the indirect costs of medical edu-
22 cation under section 1886(d)(5)(B), or for di-
23 rect graduate medical education costs under
24 section 1886(h).

1 “(I) NATIONAL AVERAGE PER CAPITA
 2 GROWTH PERCENTAGE.—For purposes of sub-
 3 paragraphs (A)(ii)(II) and (C)(i)(I), the ‘na-
 4 tional average per capita growth percentage’
 5 shall be the percentage determined by the Sec-
 6 retary on an annual basis (not later than Au-
 7 gust 1 before the year concerned) to reflect the
 8 Secretary’s estimate of the projected per capita
 9 rate of growth in expenditures under this title.

10 “(5) PAYMENT AREA DEFINED.—

11 “(A) IN GENERAL.—For purposes of this
 12 part, except as provided by subparagraph (B),
 13 the term ‘payment area’ means a county, or
 14 equivalent area specified by the Secretary.

15 “(B) RULE FOR ESRD BENEFICIARIES.—In
 16 the case of individuals who are determined to
 17 have end-stage renal disease, the payment area
 18 shall be a State or other area specified by the
 19 Secretary.

20 “(f) PARTIAL RISK CONTRACTS.—

21 “(1) IN GENERAL.—

22 “(A) SECRETARY’S AUTHORITY TO CON-
 23 TRACT.—The Secretary may enter into a partial
 24 risk contract under this subsection (under
 25 which payment by the Secretary for covered

1 services to individuals eligible for benefits under
2 this title shall be made as provided in para-
3 graph (2)) with any eligible organization meet-
4 ing the requirements of subparagraph (B).

5 “(B) REQUIREMENTS APPLICABLE TO
6 CONTRACTING ORGANIZATIONS.—An eligible or-
7 ganization qualified to enter a contract under
8 this subsection must meet the following require-
9 ments:

10 “(i) MINIMUM PRIVATE ENROLL-
11 MENT.—The organization must have at
12 least 1,500 members not entitled to bene-
13 fits under this title or title XIX, except in
14 such situations and under such conditions
15 as the Secretary determines will be in the
16 best interests of individuals entitled to ben-
17 efits under this title.

18 “(ii) ABILITY TO BEAR RISK.—The
19 organization must satisfy the Secretary
20 that it has the ability to bear the risk of
21 potential losses under a partial risk con-
22 tract under this subsection.

23 “(2) PAYMENTS.—The Secretary shall make
24 payments to an organization with a partial risk con-

1 tract under this subsection, for services provided
2 under such contract, as follows:

3 “(A) INTERIM MONTHLY PAYMENTS.—The
4 Secretary shall make payments over a 12-month
5 period in amounts equal to 95 percent of modi-
6 fied fee for service amounts (as defined in para-
7 graph (4)).

8 “(B) FINAL RETROSPECTIVE ADJUST-
9 MENT.—After the end of such 12-month period,
10 the Secretary shall make a final payment ad-
11 justment, as follows:

12 “(i) IF PLAN COSTS ARE BELOW
13 TOTAL ANNUAL CAPITATION PAYMENTS.—
14 If 100 percent of the modified fee for serv-
15 ice amounts paid under subparagraph (A)
16 for that period were less than total annual
17 capitation payments (as defined in para-
18 graph (4)), the Secretary shall pay the or-
19 ganization (in addition to the amounts
20 paid under subparagraph (A)) 5 percent of
21 modified fee for service amounts, plus one-
22 half of the difference between the total an-
23 nual capitation payments and 100 percent
24 of the modified fee for service amounts
25 paid under subparagraph (A).

1 “(ii) IF PLAN COSTS ARE BETWEEN
2 THE TOTAL ANNUAL CAPITATION PAY-
3 MENTS AND 110 PERCENT OF SUCH PAY-
4 MENTS.—If 100 percent of the modified
5 fee for service amounts paid made under
6 subparagraph (A) equal to or greater than
7 total annual capitation payments, but not
8 more than 110 percent of such amount,
9 the Secretary shall pay the organization an
10 additional amount (in addition to the
11 amounts paid under subparagraph (A))
12 such that the total amounts paid the orga-
13 nization equal the sum of the total annual
14 capitation payments plus one-half of the
15 difference between 100 percent of the
16 modified fee for service amounts and total
17 annual capitation payments.

18 “(iii) IF PLAN COSTS ARE GREATER
19 THAN 110 PERCENT OF TOTAL ANNUAL
20 CAPITATION PAYMENTS.—If 100 percent of
21 the modified fee for service amounts paid
22 under subparagraph (A) exceeded 110 per-
23 cent of total annual capitation payments,
24 the Secretary shall pay the organization, or
25 the organization shall refund to the Sec-

1 retary, an amount such that the total
 2 amounts paid the organization equal 105
 3 percent of total annual capitation pay-
 4 ments.

5 “(3) NONRENEWAL FOR EXCESSIVE COSTS.—If
 6 paragraph (2)(B)(iii) applies two years in succes-
 7 sion, the contract shall not be renewed.

8 “(4) DEFINITIONS.—

9 “(A) MODIFIED FEE FOR SERVICE
 10 AMOUNTS.—For purposes of this subsection,
 11 ‘modified fee for service amounts’ are the
 12 amounts that the Secretary would have paid
 13 under this title (other than under this part) ex-
 14 cluding payment adjustments under section
 15 1886(d)(5)(F) for hospitals serving a dispropor-
 16 tionate share of low-income patients, for the in-
 17 direct costs of medical education under section
 18 1886(d)(5)(B), or for direct graduate medical
 19 education costs under section 1886(h).

20 “(B) TOTAL ANNUAL CAPITATION PAY-
 21 MENTS.—For purposes of this subsection, ‘total
 22 annual capitation payments’ are equal to the
 23 total payments that the eligible organization
 24 would have received for the year if it had a con-

1 tract under subsection (e) instead of under this
2 subsection.

3 “(g) MINIMUM PERIOD OF NONPARTICIPATION
4 AFTER CONTRACT TERMINATION.—

5 “(1) IN GENERAL.—The Secretary may not
6 enter into a contract with an eligible organization
7 under this part, except in circumstances (as deter-
8 mined by the Secretary) which warrant special con-
9 sideration, if a previous contract with that organiza-
10 tion was terminated within the preceding five-year
11 period—

12 “(A) at the request of the organization; or

13 “(B) pursuant to subsection (f)(3), for ex-
14 cessive costs under a partial risk contract.

15 “(2) INAPPLICABILITY TO CONTRACT CONVER-
16 SIONS.—For purposes of the requirement of para-
17 graph (1), a conversion from a risk to a partial risk
18 contract shall not be considered a contract termi-
19 nation.

20 “(h) SPECIAL RULE FOR HOSPITALIZED PA-
21 TIENTS.—A contract under this part shall provide that in
22 the case of an individual who is receiving inpatient hos-
23 pital services from a subsection (d) hospital (as defined
24 in section 1886(d)(1)(B)) as of the effective date of the
25 individual’s—

1 “(1) enrollment with an eligible organization
2 under this part—

3 “(A) payment for such services until the
4 date of the individual’s discharge shall be made
5 under this title as if the individual were not en-
6 rolled with the organization,

7 “(B) the organization shall not be finan-
8 cially responsible for payment for such services
9 until the date after the date of the individual’s
10 discharge, and

11 “(C) the organization shall nonetheless be
12 paid the full amount otherwise payable to the
13 organization under this part, or

14 “(2) termination of enrollment with an eligible
15 organization under this part—

16 “(A) the organization shall be financially
17 responsible for payment for such services after
18 such date and until the date of the individual’s
19 discharge,

20 “(B) payment for such services during the
21 stay shall not be made under section 1886(d),
22 and

23 “(C) the organization shall not receive any
24 payment with respect to the individual under

1 this part during the period the individual is not
2 enrolled.

3 “(i) SPECIAL RULE FOR NATIONAL COVERAGE DE-
4 TERMINATION.—

5 “(1) If the Secretary makes a determination
6 with respect to coverage under this title that the
7 Secretary projects will result in a significant in-
8 crease in the costs to eligible organizations of pro-
9 viding benefits under contracts under this part—

10 “(A) during an annual contract period
11 under a risk contract; or

12 “(B) during a 12-month payment period
13 under a partial risk contract,

14 the provisions of this subsection apply to benefits
15 and payments during the remainder of the term of
16 such contract.

17 “(2) COVERAGE OF EXPANDED BENEFITS.—

18 The organization shall be required to provide (or ar-
19 range for provision of) the expanded benefit to indi-
20 viduals enrolled under this part as of the date such
21 benefit would have been available to them had they
22 not been so enrolled.

23 “(3) PAYMENT FOR EXPANDED BENEFITS.—If
24 (or to the extent) the increased costs attributable to
25 the expanded benefits were not taken into account in

1 establishing per capita payment rates under a risk
2 contract, or in determining the total annual capita-
3 tion payments applicable to a partial risk contract—

4 “(A) in the case of an organization with a
5 risk contract, the Secretary shall make an addi-
6 tional payment for the provision of such ex-
7 panded benefits during such remaining portion
8 of the contract term, notwithstanding any other
9 provision of this part, equal to the amount that
10 the Secretary would have paid under this title
11 (other than under this part); and

12 “(B) in the case of an organization with a
13 partial risk contract, the applicable total annual
14 capitation payments shall be recalculated to
15 take the increased costs of such expanded bene-
16 fits into account for such remaining portion of
17 the contract term.

18 “(j) GENERAL PROVISIONS.—

19 “(1) GENERAL AUTHORITY OF SECRETARY.—

20 The authority vested in the Secretary by this part
21 may be performed without regard to such provisions
22 of law or regulations relating to the making, per-
23 formance, amendment, or modification of contracts
24 of the United States as the Secretary may determine

1 to be inconsistent with the furtherance of the pur-
2 pose of this title.

3 “(2) SERVICE AREA.—The Secretary may pre-
4 scribe criteria for the geographic area to be served
5 by an eligible organization. The criteria may vary for
6 different kinds of eligible organizations.

7 “(k) USER FEES.—

8 “(1) FEE FOR CERTIFICATION.—Each entity
9 requesting to be certified as an eligible organization
10 shall pay the Secretary for the estimated costs to be
11 incurred by the Secretary for certification activities.

12 “(2) FEE FOR MONITORING ACTIVITIES.—Eligi-
13 ble organizations with a contract under this part
14 shall pay the Secretary for the estimated costs to be
15 incurred by the Secretary for monitoring activities.

16 “(3) AUTHORIZATION.—The payments de-
17 scribed in paragraphs (1) and (2) are appropriated
18 to defray the cost described in such paragraphs, to
19 remain available until expended.

20 “(l) SPECIAL RULE FOR HOSPICE CARE.—

21 “(1) INFORMATION.—A contract under this
22 part shall require the organization to inform each in-
23 dividual enrolled under this part with the organiza-
24 tion about the availability of hospice care if—

1 “(A) a hospice participating under this
 2 title is located within the organization’s geo-
 3 graphic area; or

4 “(B) it is common practice to refer pa-
 5 tients to hospices outside the geographic area.

6 “(2) PAYMENT.—If an individual who is en-
 7 rolled with an eligible organization under this part
 8 makes an election under section 1812(d)(1) to re-
 9 ceive hospice care from a particular hospice—

10 “(A) payment for the hospice care services
 11 furnished to the individual shall be made by the
 12 Secretary for the hospices elected by the indi-
 13 vidual; and

14 “(B) payment for other services for which
 15 the individual is eligible notwithstanding the in-
 16 dividual’s election of hospice care under section
 17 1812(d)(1), including services not related to the
 18 individual’s terminal illness, shall be made by
 19 the Secretary to the eligible organization or the
 20 provider or supplier of the service in lieu of
 21 payments calculated under subsections (e) and
 22 (f).

23 **“SEC. 1851G. SANCTIONS.**

24 “(a) VIOLATIONS SUBJECT TO CIVIL MONEY PEN-
 25 ALTIES.—In addition to any other remedies authorized by

1 law, the Secretary may impose a civil money penalty in
2 accordance with subsection (c) on an eligible organization
3 with a contract under this part that has committed any
4 of the following violations.

5 “(1) FAILURE TO PROVIDE MEDICALLY NEC-
6 CESSARY CARE.—The organization has failed substan-
7 tially to provide medically necessary items and serv-
8 ices that are required (under law or under the con-
9 tract) to be provided to an individual covered under
10 the contract, if the failure has adversely affected (or
11 has substantial likelihood of adversely affecting) the
12 individual.

13 “(2) EXCESSIVE PREMIUMS.—The organization
14 has imposed premiums on individuals enrolled under
15 this part in excess of the premiums permitted.

16 “(3) DISCONTINUATION OF COVERAGE.—The
17 organization has expelled or refused to reenroll an
18 individual in violation of the provisions of this part.

19 “(4) DISCOURAGING ENROLLMENT.—The orga-
20 nization has engaged in any practice that would rea-
21 sonably be expected to have the effect of denying or
22 discouraging enrollment (except as permitted by this
23 part) by eligible individuals with the organization
24 whose medical condition or history indicates a need
25 for substantial future medical services.

1 “(5) FALSE INFORMATION.—The organization
2 has misrepresented or falsified information fur-
3 nished—

4 “(A) to the Secretary under this part, or
5 “(B) to an individual or to any other entity
6 under this part.

7 “(6) FAILURE TO COOPERATE WITH EXTERNAL
8 QUALITY REVIEW.—The organization fails to cooper-
9 ate in the performance of the review required under
10 section 1851E(e)(2).

11 “(7) PHYSICIAN INCENTIVE PLAN VIOLA-
12 TIONS.—The organization fails to comply with the
13 requirements of section 1851E(i).

14 “(8) RELATIONSHIP WITH EXCLUDED INDIVID-
15 UAL OR ENTITY.—The organization—

16 “(A) employs or contracts with any indi-
17 vidual or entity that is excluded from participa-
18 tion under this title under section 1128 or
19 1128A for the provision of health care, utiliza-
20 tion review, medical social work, or administra-
21 tive services; or

22 “(B) employs or contracts with any entity
23 for the provision (directly or indirectly) through
24 such an excluded individual or entity of such
25 services.

1 “(b) VIOLATIONS SUBJECT TO INTERMEDIATE SANC-
 2 TIONS.—In addition to any other remedies authorized by
 3 law, the Secretary may impose an intermediate sanction
 4 in accordance with subsection (d) on an eligible organiza-
 5 tion with a contract under this part that has committed
 6 any of the following violations:

7 “(1) VIOLATION SUBJECT TO CIVIL MONEY
 8 PENALTY.—Any violation specified in subsection (a).

9 “(2) GROUNDS FOR TERMINATION OF CON-
 10 TRACT.—Any violation that would be grounds for
 11 termination of the contract with the organization
 12 pursuant to section 1851F(b)(2).

13 “(3) FAILURE TO MAKE PROMPT PAYMENT.—
 14 Failure to make prompt payment as required by sec-
 15 tion 1851F(d).

16 “(4) DELAYED COVERAGE DETERMINATIONS.—
 17 Failure to meet timeliness standards for coverage
 18 determinations under section 1851E(d)(1).

19 “(5) INSUFFICIENT PRIVATE ENROLLMENT.—
 20 Failure to meet the minimum requirements of sec-
 21 tion 1851E(g).

22 “(c) CIVIL MONEY PENALTIES.—

23 “(1) AMOUNT OF PENALTY.—The Secretary
 24 may impose, on an eligible organization determined
 25 to have committed a violation specified in subsection

1 (a), civil money penalties not to exceed the sum of
2 the following amounts, as applicable:

3 “(A) For each such determination, not
4 more than—

5 “(i) \$100,000, in the case of a deter-
6 mination under subsection (a) (4) or
7 (5)(A); or

8 “(ii) \$25,000, in the case of any other
9 such determination.

10 “(B) With respect to a determination
11 under subsection (a)(2), double the excess
12 amount charged (and the excess amount
13 charged shall be deducted from the penalty and
14 returned to the individual concerned).

15 “(C) With respect to a determination
16 under subsection (a)(4), \$15,000 for each indi-
17 vidual not enrolled as a result of the practice
18 involved.

19 “(2) ADMINISTRATIVE PROCEDURE.—The pro-
20 visions of section 1128A (other than subsections (a)
21 and (b) shall apply to a civil money penalty under
22 this section in the same manner as they apply to a
23 civil money penalty or proceeding under section
24 1128A(a).

1 “(d) INTERMEDIATE SANCTIONS.—The Secretary
2 may impose, on an eligible organization determined to
3 have committed a violation specified in subsection (a) or
4 (b), either or both of the following sanctions.

5 “(1) SUSPENSION OF ENROLLMENT.—Suspension
6 of enrollment of individuals with the organization
7 under this part after the date the Secretary notifies
8 the organization of a determination under subsection
9 (a) or (b) and until the Secretary is satisfied
10 that the basis for such determination has been corrected
11 and is not likely to recur.

12 “(2) SUSPENSION OF PAYMENT.—Suspension of
13 payment to the organization under this part for individuals
14 enrolled after the date the Secretary notifies
15 the organization of a determination under subsection
16 (a) or (b) and until the Secretary is satisfied that
17 the basis for such determination has been corrected
18 and is not likely to recur.

19 **“SEC. 1851H. ALTERNATIVE CERTIFICATION AND MONITOR-**
20 **ING PROGRAM.**

21 “(a) IN GENERAL.—The Secretary shall develop a
22 program under which States using Federal standards
23 could certify entities as eligible organizations and assist
24 in monitoring eligible organizations with contracts under
25 section 1851F.

1 “(b) CRITERIA FOR STATE PARTICIPATION.—States
2 can participate in the program described in subsection (a)
3 if upon the request of a State the Secretary determines
4 that—

5 “(1) the State’s standards are substantially
6 equivalent to Federal standards for certification as
7 an eligible organization;

8 “(2) the State has the ability and sufficient re-
9 sources to carry out the certification function to the
10 Secretary’s satisfaction; and

11 “(3) the State has the ability and sufficient re-
12 sources to carry out the monitoring function to the
13 Secretary’s satisfaction.

14 “(c) FEDERAL ROLE AFTER APPROVAL OF STATE
15 PROGRAM.—

16 “(1) ‘LOOK-BEHIND’ FUNCTION.—The Sec-
17 retary will periodically review the performance of
18 State programs under this section to ensure contin-
19 ued compliance with the requirements under sub-
20 section (b). Such review program shall include re-
21 view of a sample of plans certified in each State.

22 “(2) FEDERAL ADMINISTRATIVE AND OVER-
23 SIGHT ACTIVITIES.—In developing the program
24 under this section, the Secretary would retain, at a
25 minimum, responsibility for enrollment and

1 disenrollment of Medicare beneficiaries, payment to
2 plans, approval of adjusted community rate (ACR)
3 proposals and supplemental benefits, approval of
4 Medicare marketing material, development of com-
5 parative materials, monitoring resolution of com-
6 plaints, administering the Medicare reconsideration
7 and appeals process, reviewing and approving re-
8 quests for waivers of the 50/50 and minimum enroll-
9 ment requirements, and managing the external qual-
10 ity review program.

11 “(3) ENFORCEMENT ACTIVITIES.—The Sec-
12 retary will determine the appropriate sanctions or
13 contract actions against plans that are out of com-
14 pliance with standards.

15 “(4) CONTRACTING AUTHORITY.—In general,
16 once a State has certified an entity as an eligible or-
17 ganization, the entity is eligible for a contract under
18 section 1851F. However, the Secretary can deny a
19 contract to an otherwise eligible organization if the
20 Secretary determines either that the organization
21 cannot bear the level of risk required under the con-
22 tract, or that the organization is not otherwise able
23 to administer a contract effectively.

24 “(d) USE OF MORE STRINGENT STANDARDS.—Be-
25 ginning in 1999, States participating in the program de-

1 scribed in this section could impose more stringent re-
 2 quirements in certifying eligible organizations and in mon-
 3 itoring eligible organizations with contracts under section
 4 1851F, if such requirements—

5 “(1) have been approved by the Secretary, and

6 “(2) are imposed on health plans in a non-
 7 discriminatory manner.

8 **“SEC. 1851I. DEFINITIONS.**

9 “(a) ADJUSTED COMMUNITY RATE.—

10 “(1) IN GENERAL.—For purposes of this part,
 11 the term ‘adjusted community rate’ for a service or
 12 services means, at the election of an eligible organi-
 13 zation, either—

14 “(A) the rate of payment for that service
 15 or services which the Secretary annually deter-
 16 mines would apply to a member enrolled under
 17 this part with an eligible organization if the
 18 rate of payment were determined under a ‘com-
 19 munity rating system’ (as defined in section
 20 1302(8) of the Public Health Service Act, other
 21 than subparagraph (C)), or

22 “(B) such portion of the weighted aggre-
 23 gate premium, which the Secretary annually es-
 24 timates would apply to a member enrolled
 25 under this part with the eligible organization,

1 as the Secretary annually estimates is attrib-
2 utable to that service or services,
3 adjusted in accordance with paragraph (2).

4 “(2) ADJUSTMENT OF DIFFERENCES IN UTILI-
5 ZATION.—The rate determined in accordance with
6 subparagraphs (A) and (B) of paragraph (1) shall
7 be adjusted for—

8 “(A) the differences between the utilization
9 characteristics of the members enrolled with the
10 eligible organization under this part and the
11 utilization characteristics of the other members
12 of the organization; or

13 “(B) (if the Secretary finds that adequate
14 data are not available to calculate the adjust-
15 ment pursuant to subparagraph (A)) the dif-
16 ferences between—

17 “(i) the utilization characteristics of
18 members in other eligible organizations, or
19 individuals in the area, in the State, or in
20 the United States, eligible to enroll under
21 this part with an eligible organization, and

22 “(ii) the utilization characteristics of
23 the rest of the population in the area, in
24 the State, or in the United States, respec-
25 tively.

1 “(b) ADJUSTED AVERAGE PER CAPITA COST
 2 (AAPCC).—For purposes of this part, the term ‘AAPCC’
 3 (adjusted average per capita cost) means the average per
 4 capita amount that the Secretary estimates in advance (on
 5 the basis of actual experience, or retrospective actuarial
 6 equivalent based upon an adequate sample and other in-
 7 formation and data, in a geographic area served by an
 8 eligible organization or in a similar area, with appropriate
 9 adjustments to assure actuarial equivalence) would be pay-
 10 able in any contract year for services covered under parts
 11 A and B, or part B only, and types of expenses otherwise
 12 reimbursable under parts A and B, or part B only (includ-
 13 ing administrative costs incurred by organizations de-
 14 scribed in sections 1816 and 1842), if the services were
 15 to be furnished by other than an eligible organization or,
 16 in the case of services covered only under section
 17 1861(s)(2)(H), if the services were to be furnished by a
 18 physician or as an incident to a physician’s service.”.

19 (b) REPEAL OF SUPERSEDED PROVISION.—Section
 20 1876 (42 U.S.C. 1395mm) is repealed, except to the ex-
 21 tent provided in subsection (e).

22 (c) CONFORMING AMENDMENTS.—

23 (1) Section 1154(a)(4)(B) (42 U.S.C. 1320c-
 24 3(a)(4)(B)) is amended—

1 (A) in the first sentence, by striking “risk-
2 sharing contract under section 1876” and in-
3 serting “contract under part C of title XVIII”,
4 and

5 (B) in the second sentence, by striking “a
6 health maintenance organization or competitive
7 medical plan under section 1876” and inserting
8 “an eligible organization under part C of title
9 XVIII”.

10 (2) The second sentence of section
11 1154(a)(4)(C) (42 U.S.C. 1320c-3(a)(4)(C)) is
12 amended by striking “section 1876” and inserting
13 “part C of title XVIII”.

14 (3) Section 1866(a)(1)(O) (42 U.S.C.
15 1395cc(a)(1)(O)) is amended by striking “risk-shar-
16 ing contract under section 1876” and inserting
17 “contract under part C”.

18 (4) The matter in the first sentence of section
19 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) preceding sub-
20 paragraph (A) is amended by striking “1876(c)(8)”
21 and inserting “1851E(f)”.

22 (5) Section 1866(f)(2)(E) (42 U.S.C.
23 1395cc(f)(2)(E)) is amended by striking “1876(b)”
24 and inserting “1851A(a)”.

1 (6) Section 1882(g)(1) (42 U.S.C.
2 1399ss(g)(1)) is amended—

3 (A) by striking “1876(b)” and inserting
4 “1851A”; and

5 (B) by striking “section 1876” and insert-
6 ing “part C”.

7 (d) EFFECTIVE DATE.—Except to the extent other-
8 wise provided, the amendments made by the preceding
9 subsections apply to items and services furnished after
10 1996.

11 (e) TRANSITION PROVISIONS FOR COST CON-
12 TRACTS.—

13 (1) REPEAL OF AUTHORITY FOR COST CON-
14 TRACTS DELAYED TO 2001.—The amendments made
15 by the preceding subsections (other than the amend-
16 ments specified in paragraph (2)) do not apply to
17 items and services furnished before 2001 under a
18 contract under section 1876(h) of the Social Secu-
19 rity Act (42 U.S.C. 1395mm(h)).

20 (2) PROVISIONS WHOSE EFFECT IS NOT DE-
21 LAYED.—The effective dates of the following provi-
22 sions of part C of the Social Security Act (as added
23 by subsection (a)(2) of this section) shall not be de-
24 layed by reason of paragraph (1):

1 (A) DEFINITION OF QUALIFIED HMO.—
 2 Section 1851A(b).

3 (B) ENROLLMENT AND DISENROLL-
 4 MENT.—Section 1851B.

5 (C) BENEFICIARY PROTECTIONS.—Sub-
 6 sections (a) (explanation of patients' rights and
 7 restrictions), (c) (grievance mechanism), (d)
 8 (coverage determinations and appeals), and (g)
 9 (private enrollment requirements) of section
 10 1851E.

11 (3) OPTION RESTRICTED TO GRANDFATHERED
 12 ORGANIZATIONS.—With respect to services provided
 13 after 1996 but before 2001, the Secretary of Health
 14 and Human Services (in this section referred to as
 15 the “Secretary”) may enter into contracts under
 16 subsection (h) of section 1876 of the Social Security
 17 Act (42 U.S.C. 1395mm) only with entities with
 18 which the Secretary has entered into contracts under
 19 that subsection for all or part of 1996, or to which
 20 payments have been made during 1996 under sec-
 21 tion 1833(a)(1)(A) of such Act (42 U.S.C.
 22 1395l(a)(1)(A)).

23 (f) REGULATIONS.—

24 (1) CONTINUITY OF CURRENT REGULATIONS.—
 25 Regulations in effect (or available in proposed form)

1 on December 31, 1996, that apply to section 1876
2 of the Social Security Act (42 U.S.C. 1395mm) shall
3 apply to part C of title XVIII of that Act (as added
4 by subsection (a)(2)), except to the extent that the
5 regulations are inconsistent with the provisions of
6 that part.

7 (2) INTERIM FINAL REGULATIONS.—The Sec-
8 retary may issue regulations before 1998 for part C
9 of title XVIII of the Social Security Act (as added
10 by subsection (a)(2)) on an interim final basis.

11 (g) CONSIDERATION OF EXPERIENCE UNDER SEC-
12 TION 1876 IN SATISFACTION OF REQUIREMENTS OF PART
13 C.—Any requirement in part C of title XVIII of the Social
14 Security Act (as added by subsection (a)(2)) that (in a
15 particular context) relates to matters that occurred before
16 1997 shall be satisfied if the corresponding requirement
17 was satisfied under section 1876 (42 U.S.C. 1395mm) of
18 such Act.

19 (h) ENROLLMENT TRANSITION RULE.—An individ-
20 ual who is enrolled on December 31, 1996, with an eligible
21 organization under section 1876 of the Social Security Act
22 (42 U.S.C. 1395mm) shall be considered to be enrolled
23 with that organization on January 1, 1997, under part
24 C of title XVIII of that Act (as added by subsection
25 (a)(2)) if that organization has a contract under such part

1 for providing services on January 1, 1997 (unless the indi-
 2 vidual has disenrolled effective on that date).

3 (i) IMMEDIATE EFFECTIVE DATE FOR CERTAIN RE-
 4 QUIREMENTS FOR DEMONSTRATIONS.—Section
 5 1851B(b)(2) of the Social Security Act (as added by sub-
 6 section (a)(2)) (requiring contribution to certain costs re-
 7 lated to the enrollment process comparative materials) ap-
 8 plies to demonstrations occurring after the date of enact-
 9 ment of this Act.

10 **SEC. 11203. DEVELOPMENT OF FEDERAL STANDARDS.**

11 (a) PUBLISHING REGULATIONS.—By January 1,
 12 1997, the Secretary of Health and Human Services shall
 13 develop and promulgate interim final regulations for—

14 (1) certification standards for eligible organiza-
 15 tions under section 1851A(a) (as added by section
 16 11202);

17 (2) standards for fiscal soundness and require-
 18 ments concerning adequate protection against the
 19 risk of insolvency for provider sponsored organiza-
 20 tions seeking certification as an eligible organization;

21 (3) standards for monitoring eligible organiza-
 22 tions with contracts under section 1851F (as added
 23 by such section); and

1 (4) any other standards or procedures required
 2 to implement provisions of part C (as added by such
 3 section).

4 (b) CONSULTATION.—In developing the regulations
 5 described in subsection (a), the Secretary of Health and
 6 Human Services shall consult, among others, with the Na-
 7 tional Association of Insurance Commissioners, organiza-
 8 tions that provide or pay for health care services, and
 9 consumer organizations.

10 **SEC. 11204. APPLICABILITY OF MEDICARE RATES TO EN-**
 11 **ROLLEES WHO USE AN OUT-OF-PLAN PRO-**
 12 **VIDER OF SERVICES.**

13 (a) IN GENERAL.—Section 1866(a)(1)(O) (42 U.S.C.
 14 1395cc(a)(1)(O)) is amended—

15 (1) by striking “in the case of hospitals and
 16 skilled nursing facilities,”;

17 (2) by striking “inpatient hospital and extended
 18 care services that are covered under this title and”
 19 and inserting “services that”; and

20 (3) by striking “(in the case of hospitals) or
 21 limits (in the case of skilled nursing facilities)”.

22 (b) EFFECTIVE DATE.—The amendment made by
 23 subsection (a) applies to services furnished after 1996.

1 **SEC. 11205. SUBSTITUTION OF QUALITY MEASUREMENT**
2 **SYSTEM FOR PRIVATE ENROLLMENT RE-**
3 **QUIREMENT.**

4 (a) PROMULGATION OF REGULATIONS.—The Sec-
5 retary of Health and Human Services, after consulting
6 with representatives from managed health care plans (in-
7 cluding representatives of provider service organizations),
8 consumer organizations, and other major purchasers of
9 managed care services shall publish—

10 (1) proposed regulations by July 1, 1997, re-
11 quiring the collection, analysis, and reporting of data
12 that will permit measurement of outcomes and other
13 indices of the quality of managed care plans; and

14 (2) final regulations after completing review of
15 comments on the proposed regulations published
16 pursuant to paragraph (1).

17 (b) REVISION OF BENEFICIARY PROTECTION RE-
18 QUIREMENT.—As of the effective date of final regulations
19 published pursuant to subsection (a), section 1851E(g)
20 (as added by section 11202(a)(2) of this Act) is amended
21 to read as follows:

22 “(g) QUALITY MEASUREMENT SYSTEM.—Each eligi-
23 ble organization with which the Secretary enters into a
24 contract under this part shall meet the requirements of
25 the quality measurement system established by the Sec-
26 retary in regulations.”.

1 **SEC. 11206. HMO COMPETITIVE PRICING AND RELATED**
2 **DEMONSTRATIONS.**

3 (a) AMENDMENT EFFECTIVE ON DATE OF ENACT-
4 MENT.—Section 402(b) of the Social Security Amend-
5 ments of 1967 (42 U.S.C. 1395–1(b)) is amended by in-
6 serting after the first sentence the following: “The Sec-
7 retary may also waive, in the case of such an experiment
8 or demonstration project, compliance with the require-
9 ments of sections 1876 and 1882 of that Act.”.

10 (b) AMENDMENT EFFECTIVE FOR 1997–2000.—

11 (1) The second sentence of section 402(b) of
12 the Social Security Amendments of 1967 (42 U.S.C.
13 1395b–1(b)) (as added by subsection (a) of this sec-
14 tion) is amended by inserting “and part C of title
15 XVIII” after “1882”.

16 (2) The amendment made by paragraph (1) ap-
17 plies to activities occurring after 1996.

18 (c) AMENDMENT EFFECTIVE AFTER 2000.—

19 (1) The second sentence of section 402(b) of
20 the Social Security Amendments of 1967 (42 U.S.C.
21 1395b–1(b)) (as added by subsection (a) and
22 amended by subsection (b) of this section) is further
23 amended by striking “sections 1876 and 1882” and
24 inserting “section 1882”.

25 (2) The amendment made by paragraph (1) ap-
26 plies to activities occurring after 2000.

1 (d) RECOMMENDATIONS ON NEW PAYMENT METH-
 2 ODOLOGY.—Not later than January 1, 2002, the Sec-
 3 retary of Health and Human Services shall make rec-
 4 ommendations to Congress concerning a new payment
 5 methodology for contracts under part C of title XVIII of
 6 the Social Security Act, based on the results of competitive
 7 pricing or related demonstrations.

8 **SEC. 11207. ELIMINATION OF HEALTH CARE PREPAYMENT**
 9 **PLAN OPTION FOR ENTITIES ELIGIBLE TO**
 10 **PARTICIPATE UNDER PART C.**

11 (a) ELIMINATION OF OPTION.—

12 (1) IN GENERAL.—Section 1833(a)(1)(A) (42
 13 U.S.C. 1395l(a)(1)(A)) is amended by inserting
 14 after “prepayment basis” the following: “(and either
 15 is sponsored by a union or employer, or does not
 16 provide, or arrange for the provision of, any inpa-
 17 tient hospital services)”.

18 (2) EFFECTIVE DATE.—The amendment made
 19 by paragraph (1) applies to services furnished after
 20 1996.

21 (b) MEDIGAP AMENDMENT.—Section 1882(g) (42
 22 U.S.C. 1395ss(g)) is amended by striking “, during the
 23 period beginning on the date specified in subsection
 24 (p)(1)(C) and ending on December 31, 1995,”.

1 **SEC. 11208. MEDIGAP REFORMS.**

2 (a) UNIFORM ENROLLMENT PERIODS.—

3 (1) IN GENERAL.—Section 1882(s)(2)(A) (42
4 U.S.C. 1395ss(s)(2)(A)) is amended by striking “an
5 application is submitted” and all that follows and in-
6 serting the following: “an application is submitted—

7 “(i) prior to or during the 6-month period be-
8 ginning with the first month as of the first day on
9 which the individual is 65 years of age or older and
10 is enrolled for benefits under part B;

11 “(ii) during an annual 30-day period specified
12 by the Secretary; or

13 “(iii) during a period specified by the Secretary
14 in the circumstances described in section
15 1851B(c)(2) (with respect to an individual losing
16 coverage through an organization’s termination of
17 contract or discontinuation of coverage).”.

18 (2) EFFECTIVE DATE.—The amendment made
19 by paragraph (1) is effective after 1996.

20 (b) STANDARDIZED INFORMATION.—

21 (1) PAYMENTS.—

22 (A) PRO RATA SHARE.—

23 (i) IN GENERAL.—Section 1882 (42
24 U.S.C. 1395ss) is amended by adding at
25 the end the following:

1 “(u) Each entity that offers a Medicare supplemental
 2 policy shall pay the Secretary for its pro rata share (as
 3 determined by the Secretary) of the estimated costs to be
 4 incurred by the Secretary in carrying out the requirements
 5 of the first sentence of section 1851B(b)(1) and section
 6 4360 of the Omnibus Reconciliation Act of 1990. Those
 7 payments are appropriated to defray the costs described
 8 in the preceding sentence, to remain available until ex-
 9 pended.”.

10 (ii) CONFORMING AMENDMENT.—Sec-
 11 tion 1882(c)(5) (42 U.S.C. 1395ss(c)(5))
 12 is amended by striking “(t)” and inserting
 13 “(u)”.

14 (B) FUNDING.—Section 4360(g) of the
 15 Omnibus Reconciliation Act of 1990 (42 U.S.C.
 16 1395b–4(g)) is amended to read as follows:

17 “(g) FUNDING.—For funding provisions, see section
 18 1851B(b)(2), and section 1882(u), of the Social Security
 19 Act.”.

20 (2) EFFECTIVE DATE.—The amendments made
 21 by paragraph (1) apply to demonstrations occurring
 22 after the date of enactment of this Act, and to other
 23 activities occurring after 1996.

24 (c) COMMUNITY RATING.—

1 (1) IN GENERAL.—Section 1882(c) (42 U.S.C.
2 1395ss(c)) is amended—

3 (A) by striking “and” at the end of para-
4 graph (4),

5 (B) by striking the period at the end of
6 paragraph (5) and inserting “; and”, and

7 (C) by adding after paragraph (5) the fol-
8 lowing:

9 “(6) provides for the same premium for each
10 enrollee.”.

11 (2) CONFORMING AMENDMENT.—Section
12 1882(b)(1)(B) (42 U.S.C. 1395ss(b)(1)(B)) is
13 amended by striking “(5)” and inserting “(6)”.

14 (3) EFFECTIVE DATE AND TRANSITIONAL PRO-
15 VISIONS.—The amendments made by this subsection
16 apply to policies and plans as of the beginning of
17 1997 (whether issued before or after that time), sub-
18 ject to such transitional rules as the Secretary of
19 Health and Human Services may develop after con-
20 sulting with the National Association of Insurance
21 Commissioners.

22 (d) LONG-TERM CARE INSURANCE SAFE HARBOR.—

23 (1) IN GENERAL.—Section 1882(d)(3)(C) (42
24 U.S.C. 1395ss(d)(3)(C)) is amended—

1 (A) by striking “or (iii)” and inserting
 2 “(iii)”; and

3 (B) by inserting before the period the fol-
 4 lowing: “, or (iv) the sale or issuance of a
 5 health insurance policy (or rider to an insur-
 6 ance contract which is not a health insurance
 7 policy) providing benefits only for long-term
 8 care, nursing home care, home health care, or
 9 community-based care, or any combination
 10 thereof, that coordinates against or excludes
 11 items and services available under this title, if
 12 such coordination or exclusion is disclosed in
 13 the policy’s outline of coverage.”.

14 (2) EFFECTIVE DATE AND OTHER RULES.—

15 (A) IN GENERAL.—The amendments made
 16 by this subsection shall take effect as if in-
 17 cluded in the enactment of section 4354 of
 18 OBRA–1990.

19 (B) PENALTY.—No penalty shall be im-
 20 posed under section 1882(d)(3)(A)(i) (42
 21 U.S.C. 1395ss(d)(3)(A)(i)) of the Social Secu-
 22 rity Act for any Act or omission occurring after
 23 the effective date of the amendments made by
 24 section 4354 of OBRA–1990 and before the
 25 date of the enactment of this Act relating to the

1 sale of a health insurance policy described in
2 section 1882(d)(3)(C)(iv) of the Social Security
3 Act.

4 **SEC. 11209. STANDARDIZED BENEFITS PACKAGES.**

5 (a) **MANAGED CARE.**—The Secretary of Health and
6 Human Services (in this section referred to as the “Sec-
7 retary”), not later than July 1, 1996, after consulting with
8 the National Association of Insurance Commissioners,
9 consumer groups, managed care plans, providers of health
10 care, and insurers, shall develop standard packages of ben-
11 efits (in addition to the benefits covered under title XVIII
12 of the Social Security Act (42 U.S.C. 1395 et seq.)) that
13 may be offered by eligible organizations under part C of
14 that title (as added by section 11202(a)(2) of this Act).

15 (b) **MEDIGAP.**—

16 (1) **EXAMINATION AND RECOMMENDATION.**—

17 (A) **IN GENERAL.**—The Secretary shall re-
18 quest the National Association of Insurance
19 Commissioners, in consultation with consumer
20 groups, managed care plans, providers of health
21 care, and insurers, to examine (and recommend
22 by March 1, 1997, any restructuring needed
23 for) the standard benefit packages developed
24 under section 1882(p)(2) of the Social Security
25 Act (42 U.S.C. 1395ss(p)(2)) in order to facili-

tate to the maximum extent feasible comparison across Medicare supplemental policies and benefits offered by eligible organizations under section 1876 of such Act.

(B) RESTRUCTURE.—The Secretary, not later than May 1, 1997, after taking into account any recommendations made under subparagraph (A) by the National Association of Insurance Commissioners, shall restructure, as needed, those standard benefit packages.

(2) AMENDMENTS.—

(A) BENEFITS.—Section 1882(p) (42 U.S.C. 1395ss(p)) is amended by adding at the end the following:

“(11) The groups or packages of benefits (including the core group of basic benefits) under paragraph (2) shall be modified by any changes made by the Secretary under section 11209(b)(1)(B) of the Emergency Medicare Protection Act of 1996.”.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services provided after 1997.

SEC. 11210. ANTITRUST RULE OF REASON STANDARD.

In any action under the antitrust laws (or under any State law similar to the antitrust laws)—

1 (1) the conduct of an organization that provides
 2 health care services in negotiating, making, or per-
 3 forming a contract (including the establishment and
 4 modification of a fee schedule and the development
 5 of a panel of physicians) under part C of title XVIII
 6 of the Social Security Act (as added by section
 7 11202(a)(2)), and

8 (2) the conduct of any member of such an orga-
 9 nization in carrying out such a contract,
 10 shall not be deemed illegal per se if each member of the
 11 organization shares, directly or indirectly, substantial fi-
 12 nancial risk in connection with the organization's oper-
 13 ations.

14 **SEC. 11211. REFORM OF THE CLINICAL LABORATORY IM-**
 15 **PROVEMENT AMENDMENTS OF 1988.**

16 (a) REDUCED REQUIREMENTS FOR CERTIFICATES.—
 17 Section 353(d)(1) of the Public Health Service Act (42
 18 U.S.C. 263a(d)(1)) is amended—

19 (1) by striking “or have its certificate renewed”
 20 in the matter preceding subparagraph (A);

21 (2) by amending clause (ii) of subparagraph (A)
 22 to read as follows:

23 “(ii) that describes the characteristics
 24 of the laboratory examinations and other
 25 procedures performed by the laboratory,

1 including the number and type of labora-
2 tory examinations and procedures, and”;
3 and

4 (3) by adding after subparagraph (E) the fol-
5 lowing:

6 “A certificate may be renewed by the Secretary after
7 the Secretary verifies certain essential information in
8 a renewal process established by the Secretary not
9 later than July 1, 1996.”.

10 (b) ANNOUNCEMENT OF INSPECTIONS.—Section
11 353(g)(1) of the Public Health Service Act (42 U.S.C.
12 263a(g)(1)) is amended—

13 (1) in the first sentence, by striking “, on an
14 announced or unannounced basis,”; and

15 (2) by adding at the end the following: “All in-
16 spections under this paragraph which are routine
17 shall be announced and inspections under this para-
18 graph which are based on a complaint or other rea-
19 son to believe a laboratory may not be in compliance
20 with the requirements of subsection (d) or the stand-
21 ards issued under subsection (f) may be unan-
22 nounced.”.

23 (c) FLEXIBLE INSPECTIONS OF UNACCREDITED
24 LABORATORIES.—The next to last sentence of section
25 353(g)(2) of the Public Health Service Act (42 U.S.C.

1 263a(g)(2)) is amended to read as follows: “Inspections
 2 of laboratories not accredited under subsection (e) shall
 3 be conducted with such frequency as the Secretary deter-
 4 mines to be necessary to assure compliance with perform-
 5 ance-based criteria established by the Secretary not later
 6 than January 1, 1997, except that such inspections may
 7 not be conducted more frequently than biennially unless
 8 the Secretary has received a complaint or has other reason
 9 to believe that the laboratory may not be in compliance
 10 with the requirements of subsection (d) or the standards
 11 issued under subsection (f).”.

12 **SEC. 11212. MODIFICATIONS TO EXCEPTIONS FOR CER-**
 13 **TAIN ARRANGEMENTS.**

14 (a) EXCEPTIONS FOR BOTH OWNERSHIP AND COM-
 15 PENSATION ARRANGEMENTS.—

16 (1) REPEAL OF EXCEPTION FOR PHYSICIANS’
 17 SERVICES.—Section 1877(b) (42 U.S.C. 1395nn(b))
 18 is amended by striking “Subsection (a)(1) shall not
 19 apply in the following cases:” and all that follows
 20 through the end of paragraph (1).

21 (2) NEW EXCEPTION FOR SHARED FACILITY
 22 SERVICES.—Section 1877(b) (42 U.S.C. 1395nn(b)),
 23 as amended by paragraph (1), is amended by insert-
 24 ing before paragraph (2) the following:

25 “(1) SHARED FACILITY SERVICES.—

1 “(A) IN GENERAL.—Subsection (a)(1)
 2 shall not apply in the case of a designated
 3 health service consisting of a shared facility
 4 service of a shared facility—

5 “(i) that is furnished—

6 “(I) personally by the referring
 7 physician who is a shared facility phy-
 8 sician or personally by an individual
 9 directly employed by such a physician,

10 “(II) by a shared facility in a
 11 building in which the referring physi-
 12 cian furnishes substantially all of the
 13 services of the physician that are un-
 14 related to the furnishing of shared fa-
 15 cility services, and

16 “(III) to a patient of a shared fa-
 17 cility physician; and

18 “(ii) that is billed by the referring
 19 physician.

20 “(B) SHARED FACILITY RELATED DEFINI-
 21 TIONS.—

22 “(i) SHARED FACILITY SERVICE.—

23 The term ‘shared facility service’ means,
 24 with respect to a shared facility, a des-
 25 ignated health service furnished by the fa-

1 cility to patients of shared facility physi-
2 cians.

3 “(ii) SHARED FACILITY.—The term
4 ‘shared facility’ means an entity that fur-
5 nishes shared facility services under a
6 shared facility arrangement.

7 “(iii) SHARED FACILITY PHYSICIAN.—
8 The term ‘shared facility physician’ means,
9 with respect to a shared facility, a physi-
10 cian who has a financial relationship under
11 a shared facility arrangement with the fa-
12 cility.

13 “(iv) SHARED FACILITY ARRANGE-
14 MENT.—The term ‘shared facility arrange-
15 ment’ means, with respect to the provision
16 of shared facility services in a building, a
17 financial arrangement—

18 “(I) which is only between physi-
19 cians who are providing services (un-
20 related to shared facility services) in
21 the same building,

22 “(II) in which the overhead ex-
23 penses of the facility are shared, in
24 accordance with methods previously
25 determined by the physicians in the

arrangement, among the physicians in
the arrangement, and

“(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.”.

(3) INCLUSION OF DURABLE MEDICAL EQUIPMENT AND PARENTERAL AND ENTERAL NUTRIENTS, EQUIPMENT, AND SUPPLIES IN EXCEPTION FOR IN-OFFICE ANCILLARY SERVICES.—Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by striking “In the case of” and all that follows through “supplies)” and inserting “Subsection (a)(1) shall not apply in the case of designated health services”.

(4) NEW EXCEPTION FOR SERVICES FURNISHED IN COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—Section 1877(b) (42 U.S.C. 1395nn(b)) is amended—

(A) by redesignating paragraph (4) as paragraph (5); and

(B) by inserting after paragraph (3) the following new paragraph:

“(4) NO ALTERNATIVE PROVIDERS IN AREA.—Subsection (a)(1) shall not apply in the case of a designated health service furnished in any area with respect to which the Secretary determines that indi-

viduals residing in the area do not have reasonable access to such a designated health service.”.

(5) NEW EXCEPTION FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by paragraph (4), is amended—

(A) by redesignating paragraph (5) as paragraph (6); and

(B) by inserting after paragraph (4) the following new paragraph:

“(5) SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Subsection (a)(1) shall not apply in the case of a designated health service furnished in an ambulatory surgical center described in section 1832(a)(F)(i).”.

(6) NEW EXCEPTION FOR SERVICES FURNISHED IN A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by the preceding paragraphs, is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

“(6) SERVICES FURNISHED BY A HOSPICE PROGRAM.—Subsection (a)(1) shall not apply in the case

1 of a designated health service furnished by a hospice
 2 program under section 1861(dd)(2).”.

3 (7) CONFORMING AMENDMENTS.—Paragraphs
 4 (3) and (7) of section 1877(b) (42 U.S.C.
 5 1395nn(b)), as redesignated by paragraph (6), are
 6 each amended by striking “In the case of” and in-
 7 serting “Subsection (a)(1) shall not apply in the
 8 case of”.

9 (b) REVISION OF EXCEPTIONS FOR CERTAIN COM-
 10 PENSATION ARRANGEMENTS.—

11 (1) EXCEPTION FOR ALL ARRANGEMENTS
 12 MEETING REQUIREMENTS.—Section 1877(a)(2)(B)
 13 (42 U.S.C. 1395nn(a)(2)(B)) is amended—

14 (A) by striking “except as provided in sub-
 15 section (e),”; and

16 (B) by striking “entity.” and inserting
 17 “entity which does not meet the requirements
 18 of subsection (e).”.

19 (2) REQUIREMENTS DESCRIBED.—Section
 20 1877(e) (42 U.S.C. 1395nn(e)) is amended to read
 21 as follows:

22 “(e) REQUIREMENTS FOR PERMISSIBLE COMPENSA-
 23 TION ARRANGEMENTS.—The requirements under this
 24 subsection with respect to a compensation arrangement
 25 are as follows:

1 “(1) The arrangement is in writing and is
2 signed by all parties to the arrangement.

3 “(2) The arrangement is consistent with fair
4 market value.

5 “(3) The amount of compensation under the ar-
6 rangement is not determined in a manner that takes
7 into account the volume or value of any referrals or
8 other business generated between the parties. Not-
9 withstanding the preceding sentence, nothing in this
10 paragraph shall prohibit the payment of remunera-
11 tion in the form of a productivity bonus based on
12 services, other than designated health services, per-
13 formed personally by the physician (or an immediate
14 family member of such physician).

15 “(4) The arrangement would be commercially
16 reasonable even if no referrals were made between
17 the parties.

18 “(5) The items and services compensated or
19 contracted for do not exceed those that are reason-
20 able and necessary for the legitimate business pur-
21 poses of the arrangement.

22 “(6) The arrangement meets such other re-
23 quirements as the Secretary may impose as needed
24 to protect against program or patient abuse.”.

1 (c) REMOVAL OF HOSPITAL SERVICES FROM LIST OF
 2 DESIGNATED HEALTH SERVICES.—Section 1877(h)(6)
 3 (42 U.S.C. 1395nn(h)(6)) is amended by striking sub-
 4 paragraph (K).

5 (d) EXPANSION OF RURAL EXCEPTION TO CERTAIN
 6 URBAN PROVIDERS.—Section 1877(d)(2) (42 U.S.C.
 7 1395nn(d)(2)) is amended—

8 (1) by striking “in a rural area (as defined in
 9 section 1886(d)(2)(D))”;

10 (2) by striking “substantially all” and inserting
 11 “not less than 75 percent”; and

12 (3) by striking “such a rural area” and insert-
 13 ing “a rural area (as defined in section
 14 1886(d)(2)(D))”.

15 (e) PROFITS AND PRODUCTIVITY BONUSES.—Section
 16 1877(h)(4)(B)(i) (42 U.S.C. 1395nn(h)(4)(B)(i)) is
 17 amended to read as follows:

18 “(i) PROFITS AND PRODUCTIVITY BO-
 19 NUSES.—A physician in a group practice
 20 may be paid—

21 “(I) a share of overall profits of
 22 the group so long as the share is not
 23 determined in any manner which is di-
 24 rectly related to the volume or value
 25 of referrals by such physician; or

1 “(II) a productivity bonus based
2 on services, other than designated
3 health services, personally performed
4 or incident to such personally per-
5 formed services.”.

6 (f) EXCEPTION FOR MEDICAID MANAGED CARE EN-
7 TITIES UNDER THE MEDICAID PROHIBITION.—Section
8 1903(s) (42 U.S.C. 1395nn(s)) is amended by inserting
9 after “title XVIII” the following: “(unless such service
10 was provided by an organization with a contract with a
11 State to provide services under the State plan under this
12 title (in accordance with subsection (m)))”.

13 (g) EXCLUSION OF INTRAOCULAR LENS, EYE-
14 GLASSES, AND CONTACT LENSES FROM DESIGNATED
15 HEALTH SERVICES SUBJECT TO PROHIBITIONS.—Section
16 1877(h)(6)(H) (42 U.S.C. 1395nn(h)(6)(H)) is amended
17 by striking the period at the end and inserting the follow-
18 ing: “, other than an intraocular lens inserted during or
19 subsequent to cataract surgery, eyeglasses, or contact
20 lenses.”.

21 (h) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to referrals made on or after April
23 1, 1996.

1 **TITLE III—NATIONAL COMMIS-**
2 **SION ON MEDICARE REFORM**

3 **SEC. 11301. ESTABLISHMENT OF COMMISSION.**

4 (a) ESTABLISHMENT.—There is established a Com-
5 mission to be known as the National Commission on Medi-
6 care Reform (in this title referred to as the “Commis-
7 sion”).

8 (b) MEMBERSHIP.—

9 (1) COMPOSITION.—The Commission shall be
10 composed of 15 members of whom—

11 (A) five shall be appointed by the Presi-
12 dent from among officers or employees of the
13 executive branch, private citizens of the United
14 States, or both, of whom not more than 3 shall
15 be of the same political party;

16 (B) five shall be appointed by the majority
17 leader of the Senate from among Members of
18 the Senate, private citizens of the United
19 States, or both, of whom not more than 3 shall
20 be of the same political party; and

21 (C) five shall be appointed by the Speaker
22 of the House of Representatives from among
23 Members of the House of Representatives, pri-
24 vate citizens of the United States, or both, of

1 whom not more than 3 shall be of the same po-
2 litical party;

3 (2) CHAIR.—The President shall designate a
4 Chair from among the members of the Commission.

5 (3) DATE.—The appointments of the members
6 of the Commission shall be made not later than 60
7 days after the date of the enactment of this title.

8 (c) PERIOD OF APPOINTMENT; VACANCIES.—Mem-
9 bers shall be appointed for the life of the Commission. Any
10 vacancy in the Commission shall not affect its powers, but
11 shall be filled in the same manner as the original appoint-
12 ment.

13 (d) INITIAL MEETING.—Not later than 30 days after
14 the date on which all members of the Commission have
15 been appointed, the Commission shall hold its first meet-
16 ing.

17 (e) MEETINGS.—The Commission shall meet at the
18 call of the Chair.

19 (f) QUORUM.—A majority of the members of the
20 Commission shall constitute a quorum, but a lesser num-
21 ber of members may hold hearings.

22 **SEC. 11302. DUTIES OF THE COMMISSION.**

23 (a) IN GENERAL.—The Commission shall—

24 (1) review relevant analyses of the current and
25 long-term financial condition of the Federal Hospital

1 Insurance Trust Fund and the Federal Supple-
2 mentary Medical Insurance Trust Fund established
3 under title XVIII of the Social Security Act;

4 (2) identify problems that may threaten the
5 long-term solvency of such trust funds;

6 (3) analyze potential solutions to such problems
7 that will both assure the financial integrity of the
8 Medicare program under such title and the provision
9 of appropriate benefits under such program; and

10 (4) provide appropriate recommendations to the
11 Secretary of Health and Human Services, the Presi-
12 dent, and the Congress.

13 (b) LEGISLATIVE PROPOSAL.—Not later than 1 year
14 after all of the members of the Commission have been ap-
15 pointed, the Commission shall develop a legislative pro-
16 posal that carries out the recommendations provided
17 under subsection (a)(4). Such legislative proposal shall be
18 submitted to Congress in the form of an implementing bill
19 which contains the statutory provisions necessary or ap-
20 propriate to implement the proposal. An implementing bill
21 submitted in accordance with this subsection shall be con-
22 sidered by Congress under the procedures described in sec-
23 tion 11306(b).

1 **SEC. 11303. POWERS OF THE COMMISSION.**

2 (a) HEARINGS.—The Commission may hold such
3 hearings, sit and act at such times and places, take such
4 testimony, and receive such evidence as the Commission
5 considers advisable to carry out the purposes of this title.

6 (b) INFORMATION FROM FEDERAL AGENCIES.—The
7 Commission may secure directly from any Federal depart-
8 ment or agency such information as the Commission con-
9 siderers necessary to carry out the provisions of this title.
10 Upon request of the Chair of the Commission, the head
11 of such department or agency shall furnish such informa-
12 tion to the Commission.

13 (c) POSTAL SERVICES.—The Commission may use
14 the United States mails in the same manner and under
15 the same conditions as other departments and agencies of
16 the Federal Government.

17 (d) GIFTS.—The Commission may accept, use, and
18 dispose of gifts or donations of services or property.

19 **SEC. 11304. COMMISSION PERSONNEL MATTERS.**

20 (a) COMPENSATION OF MEMBERS.—All members of
21 the Commission shall serve without any additional com-
22 pensation for their work on the Commission.

23 (b) TRAVEL EXPENSES.—The members of the Com-
24 mission appointed from among private citizens of the
25 United States shall be allowed travel expenses, including
26 per diem in lieu of subsistence, at rates authorized for em-

1 ployees of agencies under subchapter I of chapter 57 of
2 title 5, United States Code, while away from their homes
3 or regular places of business in the performance of services
4 for the Commission.

5 (c) STAFF.—

6 (1) IN GENERAL.—The Chair of the Commis-
7 sion may, without regard to the civil service laws
8 and regulations, appoint and terminate an executive
9 director and such other additional personnel as may
10 be necessary to enable the Commission to perform
11 its duties.

12 (2) COMPENSATION.—The Chair of the Com-
13 mission may fix the compensation of the executive
14 director and other personnel without regard to the
15 provisions of chapter 51 and subchapter III of chap-
16 ter 53 of title 5, United States Code, relating to
17 classification of positions and General Schedule pay
18 rates, except that the rate of pay for the executive
19 director and other personnel may not exceed the rate
20 payable for level V of the Executive Schedule under
21 section 5316 of such title.

22 (d) DETAIL OF GOVERNMENT EMPLOYEES.—Any
23 Federal Government employee may be detailed to the
24 Commission without reimbursement, and such detail shall

1 be without interruption or loss of civil service status or
2 privilege.

3 (e) **PROCUREMENT OF TEMPORARY AND INTERMIT-**
4 **TENT SERVICES.**—The Chair of the Commission may pro-
5 cure temporary and intermittent services under section
6 3109(b) of title 5, United States Code, at rates for individ-
7 uals which do not exceed the daily equivalent of the annual
8 rate of basic pay prescribed for level V of the Executive
9 Schedule under section 5316 of such title.

10 **SEC. 11305. TERMINATION OF THE COMMISSION.**

11 The Commission shall terminate 30 days after the
12 date on which the Commission submits its legislative pro-
13 posal to Congress under section 11302(b).

14 **SEC. 11306. CONGRESSIONAL CONSIDERATION OF COMMIS-**
15 **SION PROPOSALS.**

16 (a) **IN GENERAL.**—The implementing bill described
17 in section 11302(b) shall be considered by Congress under
18 the procedures for consideration described in subsection
19 (b).

20 (b) **INTRODUCTION AND REFERRAL.**—

21 (1) **IN GENERAL.**—On the day on which the im-
22 plementing bill described in subsection (a) is trans-
23 mitted to the House of Representatives and the Sen-
24 ate, such bill shall be introduced (by request) in the
25 House of Representatives by the majority leader of

1 the House, for himself or herself and the minority
2 leader of the House, or by Members of the House
3 designated by the majority leader and minority lead-
4 er of the House and shall be introduced (by request)
5 in the Senate by the majority leader of the Senate,
6 for himself or herself and the minority leader of the
7 Senate, or by Members of the Senate designated by
8 the majority leader and minority leader of the Sen-
9 ate. If either House is not in session on the day on
10 which the implementing bill is transmitted, the bill
11 shall be introduced in the House, as provided in the
12 preceding sentence, on the first day thereafter on
13 which the House is in session. The implementing bill
14 introduced in the House of Representatives and the
15 Senate shall be referred to the appropriate commit-
16 tees of each House.

17 (2) AMENDMENTS PROHIBITED.—No amend-
18 ment to an implementing bill shall be in order in ei-
19 ther the House of Representatives or the Senate and
20 no motion to suspend the application of this sub-
21 section shall be in order in either House, nor shall
22 it be in order in either House for the Presiding Offi-
23 cer to entertain a request to suspend the application
24 of this subsection by unanimous consent.

1 (c) DISCHARGE.—If the committee to which an im-
 2 plementing bill described in subsection (a) is referred has
 3 not reported such implementing bill (or an identical imple-
 4 menting bill) by the close of the 30th day after its intro-
 5 duction, such committee shall be, at the end of such pe-
 6 riod, discharged from further consideration of such imple-
 7 menting bill, and such implementing bill shall be placed
 8 on the appropriate calendar of the House involved.

9 (d) CONSIDERATION.—

10 (1) IN GENERAL.—On or after the third day
 11 after the date on which the committee to which such
 12 an implementing bill is referred has reported, or has
 13 been discharged (under subsection (c)) from further
 14 consideration of, such an implementing bill, it is in
 15 order (even though a previous motion to the same
 16 effect has been disagreed to) for any Member of the
 17 respective House to move to proceed to the consider-
 18 ation of the implementing bill. A Member may make
 19 the motion only on the day after the calendar day
 20 on which the Member announces to the House con-
 21 cerned the Member's intention to make the motion,
 22 except that, in the case of the House of Representa-
 23 tives, the motion may be made without such prior
 24 announcement if the motion is made by direction of
 25 the committee to which the implementing bill was re-

1 ferred. All points of order against the implementing
2 bill (and against consideration of the implementing
3 bill) are waived. The motion is highly privileged in
4 the House of Representatives and is privileged in the
5 Senate and is not debatable. The motion is not sub-
6 ject to amendment, or to a motion to postpone, or
7 to a motion to proceed to the consideration of other
8 business. A motion to reconsider the vote by which
9 the motion is agreed to or disagreed to shall not be
10 in order. If a motion to proceed to the consideration
11 of the implementing bill is agreed to, the respective
12 House shall immediately proceed to consideration of
13 the implementing bill without intervening motion,
14 order, or other business, and the implementing bill
15 shall remain the unfinished business of the respec-
16 tive House until disposed of.

17 (2) DEBATE.—Debate on the implementing bill,
18 and on all debatable motions and appeals in connec-
19 tion therewith, shall be limited to not more than 30
20 hours, which shall be divided equally between those
21 favoring and those opposing the implementing bill.
22 An amendment to the implementing bill is not in
23 order. A motion to further limit debate is in order
24 and not debatable. A motion to postpone, or a mo-
25 tion to proceed to the consideration of other busi-

1 ness, or a motion to recommit the implementing bill
2 is not in order. A motion to reconsider the vote by
3 which the implementing bill is agreed to or disagreed
4 to is not in order.

5 (3) VOTE ON FINAL PASSAGE.—Immediately
6 following the conclusion of the debate on an imple-
7 menting bill described in subsection (a), and a single
8 quorum call at the conclusion of the debate if re-
9 quested in accordance with the rules of the appro-
10 prium House, the vote on final passage of the imple-
11 menting bill shall occur.

12 (4) APPEALS.—Appeals from the decisions of
13 the Chair relating to the application of the rules of
14 the Senate or the House of Representatives, as the
15 case may be, to the procedure relating to an imple-
16 menting bill described in subsection (a) shall be de-
17 cided without debate.

18 (e) CONSIDERATION BY OTHER HOUSE.—

19 (1) IN GENERAL.—If, before the passage by one
20 House of an implementing bill of that House de-
21 scribed in subsection (a), that House receives from
22 the other House an implementing bill described in
23 subsection (a), then the following procedures shall
24 apply:

1 (A) The implementing bill of the other
 2 House shall not be referred to a committee and
 3 may not be considered in the House receiving it
 4 except in the case of final passage as provided
 5 in subparagraph (B)(ii).

6 (B) With respect to an implementing bill
 7 described in subsection (a) of the House receiv-
 8 ing the implementing bill—

9 (i) the procedure in that House shall
 10 be the same as if no implementing bill had
 11 been received from the other House; but

12 (ii) the vote on final passage shall be
 13 on the implementing bill of the other
 14 House.

15 (2) IMPLEMENTING BILL IN RECEIVING
 16 HOUSE.—Upon disposition of the implementing bill
 17 received from the other House, it shall no longer be
 18 in order to consider the implementing bill that origi-
 19 nated in the receiving House.

20 (f) RULES OF THE SENATE AND HOUSE OF REP-
 21 RESENTATIVES.—This section is enacted by Congress—

22 (1) as an exercise of the rulemaking power of
 23 the Senate and House of Representatives, respec-
 24 tively, and as such it is deemed a part of the rules
 25 of each House, respectively, but applicable only with

1 respect to the procedure to be followed in that
2 House in the case of an implementing bill described
3 in subsection (a), and it supersedes other rules only
4 to the extent that it is inconsistent with such rules;
5 and

6 (2) with full recognition of the constitutional
7 right of either House to change the rules (so far as
8 relating to the procedure of that House) at any time,
9 in the same manner, and to the same extent as in
10 the case of any other rule of that House.

11 **SEC. 11307. AUTHORIZATION OF APPROPRIATIONS.**

12 There are authorized to be appropriated such sums
13 as are necessary to carry out the purposes of the Commis-
14 sion.

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